

TO HOSPITAL. The low requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13494
13473

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Catonridge Nursing Home		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Owings Mills d. STREET ADDRESS St. Thomas Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ANNIE E. Adams		4. DATE OF DEATH Month Day Year Dec. 31, 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-18-1863
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		9b. AGE (In years last birthday) 98 yrs.	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) No		16. SOCIAL SECURITY NO. ?	
17. INFORMANT ?		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO 420.01 Conditions, if any, which gave rise to immediate cause (b) Arteriosclerosis DUE TO 420.01 (e), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		INTERVAL BETWEEN ONSET AND DEATH immediately unknow	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/20 1961 to 12/31, 1961 , that (I) (we) last saw the deceased alive on 12/17 1961 , and that death occurred at 11:15 M, from the causes and on the date stated above.			
22a. SIGNATURE Cliff Ratliff, Jr. M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) CLIFF RATLIFF, JR.		22d. ADDRESS 4605 Edmondson ave	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1-3-1962		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY St. Charles		23d. LOCATION (City, town or county) (State) Pikesville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell		24b. REGISTRAR'S SIGNATURE Clifford S. Thomas	
ADDRESS Pikesville, Md.		25a. REC'D BY REGISTRAR DATE JAN 3 '62	

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California, Northern

Alfred H. Adams

1910-1911

House

1910-1911

1910-1911

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. The law also requires that the death certificate be retained by the attending physician and completed and filed in by the funeral director. After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5

13495

CERTIFICATE OF DEATH

13474

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb 3 yrs		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1528 Kirkwood Rd.		2. USUAL RESIDENCE (Where deceased lived in institution; Residence before admission) a. STATE Md.		b. COUNTY Balto		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Josephat A. Archambault		First		Middle		Last		4. DATE OF DEATH Dec. 24,		Month		Day		Year 19 61	
5. SEX M.		6. COLOR OR RACE W.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 6, 1907		9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Interior Decorator-Ridgeway Dec. Co.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Canada		12. CITIZEN OF WHAT COUNTRY? USA									
13. FATHER'S NAME Philip Archambault		14. MOTHER'S MAIDEN NAME Virginia unknown													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 009-05-3137		17. INFORMANT Mrs Maria Archambault 1528 Kirkwood Rd., Catonsville 28, Md.		Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Acute MYOCARDIAL INFARCTION, RECURRENT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Acute ANTERIOR MYOCARDIAL INFARCTION (c) 26 days														INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		NONE												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____									
21. I certify that (I) (this hospital) attended the deceased from NOVEMBER 27, 1961 , to Dec. 24 , 1961, that (I) (we) last saw the deceased alive on Dec. 22 , 1961, and that death occurred at 9:15 A.M. , from the causes and on the date stated above.															
22a. SIGNATURE Melvin N. Borden		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/24/61									
22c. PHYSICIAN'S NAME (Type) Melvin N. BORDEN				22d. ADDRESS 5000 BALTO NAT'L PIKE BALTO 29, MD.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/27/61		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park		23d. LOCATION (City, town or county) (State) Woodlawn, Md.									
24. FUNERAL DIRECTOR'S SIGNATURE Witzke F.D. 4101 Edmondson Ave.		ADDRESS		25a. REC'D BY REGISTRAR DATE DEC 27 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus									

12/27/51
Bureau
1100 Madison Ave.

Melvin N. Gordon

12/27/51

WOMAN

And a letterhead of the same date

009-05-3157 1228 Kirkwood Rd, Cantonville 28, Md.

Philip Archambault
Virginia

Interior Decorator-Ridgeway Dec. Co. Canada

Apr. 2, 1907

Joseph A. Archambault

1228 Kirkwood Rd.

Cantonville 2 yrs

Cantonville

Baltimore

Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13496

CERTIFICATE OF DEATH

Reg. Dist. No. 13475

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 23 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 16 Fusting Ave., House in the Pines				d. STREET ADDRESS 2010 Hillenwood Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Nellie Middle Badger Last				4. DATE OF DEATH Month Dec. Day 3 Year 1961			
5. SEX Female		6. COLOR OR RACE W.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-7-1884	
9. AGE (In years last birthday) 77 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin C. Badger				14. MOTHER'S MAIDEN NAME Jennie V. Norris			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT G. Scott Kirkley Address 15 Boone Trail, Severna Park, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 420 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Hypertensive Cardio-Vascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 30s 107s							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11/10/1961 to 12/3/1961 , that I last saw the deceased alive on 12/3/1961 , and that death occurred at 6:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Wilmer K. Gallagher				ADDRESS (Street, city or town, state) 6209 Frederick Ave. Baltimore, Md.		DATE SIGNED 12/8/61	
PHYSICIAN'S NAME (Type) Wilmer K. Gallagher							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-6-1961		22c. NAME OF CEMETERY OR CREMATORY Louden Park		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE G. Howard Strong				ADDRESS 3107 W NORTH AVE.		24a. REC'D BY REGISTRAR DEC 5 '61	
				24b. REGISTRAR'S SIGNATURE Charles E. Kline			

b. COUNTY

CITY

e. IS RESIDENCE
ON A FARM?
YES ☐ NO ☒

Month Day Year
Dec 20- 1961

IF UNDER 24 HRS	IF 24 HRS OR MORE
-----------------	-------------------

12. CITIZEN OF WHAT COUNTRY?

James Evans

Address

INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

19. WAS AUTOPS PERFORMED?
YES ☐ NO ☒

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 1B.)

(State)

DATE SIGNED
21-61

W. H. Ford M.D.

(State)

24b. REGISTRAR'S SIGNATURE

DATE DEC 26 '61

Arthur S. Kraus

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Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13498

CERTIFICATE OF DEATH

13477

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore Md		3401-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School				d. STREET ADDRESS 1508 William St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Baker Last Baker				4. DATE OF DEATH Month Dec Day 30 Year 1961			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-15-11	
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months 50 Days 30 Hours 15 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) Delaware				12. CITIZEN OF WHAT COUNTRY? ---			
13. FATHER'S NAME -- Baker				14. MOTHER'S MAIDEN NAME Margaret Bell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --				16. SOCIAL SECURITY NO. --			
17. INFORMANT Mr. Walter Sands				Address Baltimore, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X Branchopneumonia DUE TO (b) Right cerebral artery inf. or thrombosis DUE TO (c) Hemiplegia, rt. due to b. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Post Influenza Encephalitis + Paradoxism INTERVAL BETWEEN ONSET AND DEATH 5-6 days							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) ---				20g. (County) ---		20h. (State) ---	
21. I certify that (I) (this hospital) attended the deceased from 12-30-1961 , to 19 , that (I) (we) last saw the deceased alive on 12-30-1961 , and that death occurred at 12 M, from the causes and on the date stated above.							
22a. SIGNATURE Harry H. Butler				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/3/62		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk.		23d. LOCATION (City, town, or county) (State) Glen Burnie, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE JOHN F. DENNY, INC.				ADDRESS 715 Light St.		25a. REC'D BY REGISTRAR DATE JAN 4 '62	
25b. REGISTRAR'S SIGNATURE Arthur L. Hines							

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MEASURING BEAT-TO-BEAT VARIATION

1893

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 are retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 are retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 are retained by the hospital or attending physician.

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13500

CERTIFICATE OF DEATH

13479

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 7225 Stratton Way				d. STREET ADDRESS 7225 Stratton Way			
3. NAME OF DECEASED (Type or print) JOSEPH PETER BARRY JR.				4. DATE OF DEATH December 12, 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Child		8. DATE OF BIRTH Nov. 10, 1956	
9. AGE (In years last birthday) 5 yrs.		IF UNDER 1 YEAR 5 Months 12 Days 19 Hours 61 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Joseph P. Barry				14. MOTHER'S MAIDEN NAME Nola Reese			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) -				16. SOCIAL SECURITY NO. -			
17. INFORMANT Mr. Joseph P. Barry, 7225 Stratton Way, 24				Address Mr. Joseph P. Barry, 7225 Stratton Way, 24			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 351X IMMEDIATE CAUSE (a) CEREBRAL PALSY DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last, (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) -							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from FEB 25, 1957 to DEC 12, 1961 , that (I) (was) last saw the deceased alive on NOV 7, 1961 , and that death occurred at 7:45 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Ladimer G. Young M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12-13-61	
22c. PHYSICIAN'S NAME (Type) LATIMER G. YOUNG				22d. ADDRESS 3311 ST. PAUL ST, BALTIMORE 18, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/15/61		23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus		23d. LOCATION (City, State Baltimore, Maryland) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE M. F. Sadowski & Sons, 1808 Eastern Avenue				ADDRESS 1808 Eastern Avenue		25a. REC'D BY REGISTRAR DEC 14 '61	
				25b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

12550

Baltimore

Baltimore

7225 Western Ave

JOSEPH

MARY

MARY

MARY

Joseph E. Barry

of a house

Mr. Joseph E. Barry, 7225 Western Ave, Baltimore

Barry, Joseph E. Barry

Barry, Joseph E. Barry, 7225 Western Ave, Baltimore

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13501

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13480

FOR STATE
HEALTH DEPT.

1. This certificate should be executed within 24 hours after death. Delay is necessary, page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore County, MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY —			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Bethlehem Steel Company				e. STREET ADDRESS 1811 Monroe Street			
3. NAME OF DECEASED (Type or print) LEE				4. DATE OF DEATH December 7, 1961			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 13, 1901	
9. AGE (in years last birthday) 60 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. BIRTHPLACE (State or foreign country) Bethlehem Steel Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Freeman Bastfield				14. MOTHER'S MAIDEN NAME Ellen Fields			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) —				16. SOCIAL SECURITY NO. 216-10-1698			
17. INFORMANT Mary Bastfield				Address 1811 N. Monroe Street			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 3304 IMMEDIATE CAUSE (a) Subarachnoid Hemorrhage, recent and extensive DUE TO Rupture of cerebral artery aneurysm Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Howard G. Shaub				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) HOWARD G. SHAUB, M. D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Dec. 11, 1961			
22c. NAME OF CEMETERY OR CREMATORY Carver Memorial Park				22d. LOCATION (City, town, or country) Laurel, Maryland			
23. FUNERAL DIRECTOR Arlington S. Phillips				24a. REC'D BY REGISTRAR DEC 12 '61			
24b. REGISTRAR'S SIGNATURE Arthur S. Travis							

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Reg. Dist. No. **13481**

13502

1. PLACE OF BIRTH a. COUNTY <u>BALTO.</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>VILLA NOVA.</u> c. LENGTH OF STAY IN 1b <u>3 yrs.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HUGSBURG Home</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>740 Poplar Grove St. 3401-4</u> d. STREET ADDRESS <u>WOODLAWN MO.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Wm. H.</u> First Middle Last <u>BAUSMAN.</u> 4. DATE OF DEATH <u>Dec. 30.</u> Month Day Year <u>1961</u>				5. SEX <u>M.</u> 6. COLOR OR RACE <u>W.</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>June 18, 1881</u> 9. AGE (In years last birthday) <u>80</u> yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (State or foreign country) <u>Balto Co. Md</u> 12. CITIZEN OF WHAT COUNTRY? _____			
13. FATHER'S NAME <u>John Geo. BAUSMAN.</u> 14. MOTHER'S MAIDEN NAME <u>MARY C. SWEN</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____ (If yes, give war or dates of service) _____ 16. SOCIAL SECURITY NO. _____ INFORMANT <u>Records</u> Address <u>6811 Campfield Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>480X</u> IMMEDIATE CAUSE (a) <u>Broncho-pneumonia.</u> DUE TO (b) <u>Arterio Sclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Post-Viral Intestinal Gynge</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>5 yrs.</u> <u>3 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arterio-sclerosis</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) _____				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19____				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
21. I certify that I attended the deceased from <u>12/31, 1959</u> to <u>12/30, 1961</u> that I last saw the deceased alive on <u>12/29, 1961</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>4108 Liberty Hts. Balto. Md.</u> DATE SIGNED <u>7-2-62</u>				ACTUAL SIGNATURE <u>Earl L. Chambers</u> PHYSICIAN'S NAME (Type) <u>Earl L. Chambers</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u> 22b. DATE THEREOF <u>1/2/62</u> 22c. NAME OF CEMETERY OR CREMATORY <u>LOUNOON Pk.</u> 22d. LOCATION (City, town, or county) <u>BALTO. MO.</u> (State) _____				23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Deemann</u> ADDRESS <u>6067 Hay Rd</u> 24a. REGISTRY REGISTRAR _____ 24b. REGISTRAR'S SIGNATURE _____ DATE _____			

VS A15 (4)
15M 9/58

13203

(M)

CERTIFICATE OF DEATH

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TO HOSPITAL, Page 4, be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			
a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		a. STATE		b. COUNTY	
Balto.		MIDDLE RIVER		Md.		Balto.	
c. LENGTH OF STAY IN 1b		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS	
		2006 Oakland Ave.		X Middle River		2006 Oakland Ave.	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
EMMA JANE BECKMAN		Dec 25 1961					
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Female	White		March 11 1874	87 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
at home				Pa.		U. S. A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
Andrew Batt		Hollie McMillen					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give year or dates of service)		17. INFORMANT Address			
				Sons 441 Bloccum Hill Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Cerebral hemorrhage (b) Hypertensive Cardio-vascular disease (c) disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH 2 days 1 yr			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 12/25 1961 to 12/25 1961, that (I) (we) last saw the deceased alive on 19, and that death occurred at 6:45 PM M, from the causes and on the date stated above.							
22a. SIGNATURE Joseph Miceli M.D.				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) JOSEPH MICELI M.D.				22d. ADDRESS 108 S. Taylor Ave Balto. 21, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
Removal		12-26-61		Braddock Catholic		N. Braddock Pa.	
24. FUNERAL DIRECTOR'S SIGNATURE John G. Connelly				25a. REC'D BY REGISTRAR 418 Eastern Ave. Balto. 21			
				25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13504
13483
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) TOWSON c. LENGTH OF STAY IN TB - d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 707 WASHINGTON AVENUE		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON d. STREET ADDRESS 707 WASHINGTON AVE. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JAMES HENRY BELL		4. DATE OF DEATH DECEMBER 13, 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 31, 1876
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUPERVISOR CAR SHOPS		10b. KIND OF BUSINESS OR INDUSTRY B. + O. R. A.	9. AGE (In years last birthday) 85 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME ANDREW BELL		14. MOTHER'S MAIDEN NAME SUSAN WATERS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give year or dates of service) NONE		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT JAMES H. BELL, Jr.		Address 707 WASHINGTON AVE. TOWSON 4, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Respiratory Failure 200.0 DUE TO Reticulo Cell Sarcoma apx Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Hodgkins DUE TO 5-7 week		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1940 to Dec. 13, 1961 , that (I) (we) last saw the deceased alive on Dec. 9, 1961 , and that death occurred at 3:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Jo. A. Sedlack M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Jo. A. SEDLACK, M.D.		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF DEC. 16, 1961	23c. NAME OF CEMETERY OR CREMATORY MT. MARIA CEMETERY	23d. LOCATION (City, town or county) (State) TOWSON, MD.
24. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, ADDRESS TOWSON, MD.		25a. REC'D BY REGISTRAR DATE DEC 18 '61	
		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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THE TOWN OF TOWN, N.Y.
IN THE YEAR 1880

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13505

CERTIFICATE OF DEATH

Reg. Dist. No. 13484

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk (22)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>823-50th Street</u>		d. STREET ADDRESS <u>823-50th Street</u>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lena</u> Middle <u>***</u> Last <u>BENEDETTA</u>		4. DATE OF DEATH Month <u>December</u> Day <u>20th</u> Year <u>1961</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 28, 1884</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Carl Clark</u>		14. MOTHER'S MAIDEN NAME <u>Celestine ??</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-22-7217</u>	
17. INFORMANT <u>Joseph Benedetta</u>		Address <u>same as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic C. V. Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1946</u> to <u>Jan 20, 1961</u> , that I last saw the deceased alive on <u>Nov 28, 1961</u> , and that death occurred at <u>6:30 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stephen C. Mackowiak</u>		ADDRESS (Street, city or town, state) <u>6714 Holabird Avenue</u> DATE SIGNED <u>12/20/61</u>	
PHYSICIAN'S NAME (Type) <u>Stephen C. Mackowiak, M.D.</u>		<u>Baltimore 22, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/23/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart of Jesus</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Brooks Bradley, Inc., Dundalk 22, Md</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 22 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

CERTIFICATE OF DEATH

1920

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. DATE OF DEATH		7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. SIGNATURE OF REGISTRAR		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF CLERK	
JAMES J. HARRIS		Male		45		1875		Boston, Mass.		1920		Boston, Mass.		Heart Disease		Natural		J. J. Harris		J. J. Harris		J. J. Harris	
13. OCCUPATION		14. MARITAL STATUS		15. COLOR		16. RELIGION		17. EDUCATION		18. PREVIOUS ILLNESS		19. PREVIOUS SURGERY		20. PREVIOUS TRAUMA		21. PREVIOUS DRUGS		22. PREVIOUS ACCIDENTS		23. PREVIOUS OTHER		24. PREVIOUS OTHER	
Clerk		Married		White		Roman Catholic		High School		None		None		None		None		None		None		None	
25. SIGNATURE OF REGISTRAR		26. SIGNATURE OF PHYSICIAN		27. SIGNATURE OF CLERK		28. SIGNATURE OF CLERK		29. SIGNATURE OF CLERK		30. SIGNATURE OF CLERK		31. SIGNATURE OF CLERK		32. SIGNATURE OF CLERK		33. SIGNATURE OF CLERK		34. SIGNATURE OF CLERK		35. SIGNATURE OF CLERK		36. SIGNATURE OF CLERK	
J. J. Harris		J. J. Harris		J. J. Harris		J. J. Harris		J. J. Harris		J. J. Harris		J. J. Harris		J. J. Harris		J. J. Harris		J. J. Harris		J. J. Harris		J. J. Harris	

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

1920

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. DATE OF DEATH

7. PLACE OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF CLERK

13. OCCUPATION

14. MARITAL STATUS

15. COLOR

16. RELIGION

17. EDUCATION

18. PREVIOUS ILLNESS

19. PREVIOUS SURGERY

20. PREVIOUS TRAUMA

21. PREVIOUS DRUGS

22. PREVIOUS ACCIDENTS

23. PREVIOUS OTHER

24. PREVIOUS OTHER

25. SIGNATURE OF REGISTRAR

26. SIGNATURE OF PHYSICIAN

27. SIGNATURE OF CLERK

28. SIGNATURE OF CLERK

29. SIGNATURE OF CLERK

30. SIGNATURE OF CLERK

31. SIGNATURE OF CLERK

32. SIGNATURE OF CLERK

33. SIGNATURE OF CLERK

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35. SIGNATURE OF CLERK

36. SIGNATURE OF CLERK

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13506
CERTIFICATE OF DEATH
13485

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Halethorpe</u>		c. LENGTH OF STAY IN Ib <u>2 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Halethorpe</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5611 Huntshire Rd.</u>				d. STREET ADDRESS <u>5611 Huntshire Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mollie E. Bennett</u>				4. DATE OF DEATH Month <u>December</u> Day <u>28</u> Year <u>1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 9, 1892</u>	9. AGE (In years last birthday) <u>69 yrs.</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>One Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John A. Roberts</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Tobery</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Sarah Gleason 5611 Huntshire Rd</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> 420 } DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>chr Myocarditis 6 mo</u> } DUE TO (c) <u>General arteriosclerosis 2 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4 chr Hypertension</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 2, 1961</u> to <u>Dec 28, 1961</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>Dec 27, 1961</u> , and that death occurred at <u>6:15 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>B B Brumbaugh</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12/28/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>B B Brumbaugh</u>				22d. ADDRESS <u>5609 main st Chesapeake 27 Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/30/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Frederick, Frederick, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ambrose Inc. 1328 Sulphur Spring Rd.</u>				ADDRESS <u> </u>		25a. REC'D BY REGISTRAR <u> </u>	
				25b. REGISTRAR'S SIGNATURE <u> </u>		25c. DATE <u>JAN 2 '62</u>	

12508

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film G304 1/2/62 iwk

CERTIFICATE OF DEATH

Reg. Dist. No. **13486**

13507

1. PLACE OF DEATH a. COUNTY Baltimore County CATONSVILLE 28 MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 28 c. LENGTH OF STAY IN 1b 3 mos. 11 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY HARFORD Co ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKS d. STREET ADDRESS 47 MONDONER Rd, e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last MEDIA ELLEN BILLINGSLEY				4. DATE OF DEATH Month Day Year DEC. 25 1961											
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-5-1911		9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEWING FACTORY WORKER during factory				10b. KIND OF BUSINESS OR INDUSTRY N. C.				11. BIRTHPLACE (State or foreign country) N. C.				12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME TOM BROOKS						14. MOTHER'S MAIDEN NAME LAURIE CUDILL									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. yes				17. INFORMANT Address HUSBAND: PAUL BILLINGSLEY, SAME AD.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 443X IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH FEW HOURS?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELITUS.														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 12-25-61 , 19 61 , to 12-25-61 , 19 61 , that I last saw the deceased alive on 12-18-61 , 19 61 , and that death occurred at 9:45 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Spring Grove St. Hosp. 12-25-61															
ACTUAL SIGNATURE ARIS M. SIMONPOULOS M.D. Baltimore 28 Md															
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12/27/61				22c. NAME OF CEMETERY OR CREMATORY Sharon View				22d. LOCATION (City, town, or county) (State) Forest Hill, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Kurtz ADDRESS Jarrettsville Md															
24a. REC'D BY REGISTRAR DATE 12 8 '61						24b. REGISTRAR'S SIGNATURE Charles E. Kurtz									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1907

WILLIAM R. DUFF

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13508

CERTIFICATE OF DEATH

Item 23b Film G305 1/8/62 mh

13487

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 43 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore -5 c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 924 N. Eden Street d. STREET ADDRESS 924 N. Eden Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) FRED D BLAKE			4. DATE OF DEATH Month December 24 Day 1961		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 10, 1895	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months 66 Days 66
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY Warehouseman		
11. BIRTHPLACE (County & State, or foreign country) Accomac, Virginia			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Archie Blake			14. MOTHER'S MAIDEN NAME Maria White		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW-1			16. SOCIAL SECURITY NO. 227-07-2137		
17. INFORMANT Clinical Records, VA Hospital			18. ADDRESS Baltimore 18, Maryland-FORT HOWARD DIVISION		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 493X DUE TO (b) XXXXX (c)					INTERVAL BETWEEN ONSET AND DEATH 6 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Cardiovascular Disease. Arteriosclerotic Heart Disease					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Nov. 11, 1961 to Dec. 24, 1961 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Dec. 24, 1961 , and that death occurred at 12:17 A.M. from the causes and on the date stated above.					
22a. SIGNATURE Charles E. Rowan			22b. DATE SIGNED 12/24/61		
22c. PHYSICIAN'S NAME (Type) CHARLES E. ROWAN, M.D.			22d. ADDRESS VAH Balto 18, Md. Fort Howard Division		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF Dec. 28, 1961	23c. NAME OF CEMETERY OR CREMATORY ACCOMAC	23d. LOCATION (City, town or county) (State) Accomac, Virginia		
24. FUNERAL DIRECTOR'S SIGNATURE Wharton and Savage			25a. REC'D BY REGISTRAR DEC 29 '61		
25b. REGISTRAR'S SIGNATURE Charles E. Rowan					

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

13503

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13509

CERTIFICATE OF DEATH

Reg. Dist. No. 13488

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Baltimore				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5533 Ritter Ave.				d. STREET ADDRESS 5533 Ritter Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Marie Bolland				4. DATE OF DEATH Month December Day 29 Year 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 24, 1883		9. AGE (In years lost birthday) 78 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Auer				14. MOTHER'S MAIDEN NAME Elizabeth Binder			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO.		INFORMANT Alvina Bolland 5533 Ritter Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO Coronary artery Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diabetic mellitus DUE TO Generalized Arteriosclerosis (c) Nephrosclerosis Kidney							INTERVAL BETWEEN ONSET AND DEATH 10 yrs +
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from July 1, 1960 to Dec 29, 1961 , that I last saw the deceased alive on Dec 29, 1961 , and that death occurred at 7:00 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Donald W. Mintzer				ADDRESS (Street, city or town, state) 3009 Trevelyan Ave Balt.			
PHYSICIAN'S NAME (Type) DONALD W. MINTZER				DATE SIGNED BALTIMORE 14. Mch 15/61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/2/62		22c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Brooklyn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 4210 Belair Road.				24a. REC'D BY REGISTRAR DATE JAN 4 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13508

M

THE STATE OF TEXAS,
COUNTY OF DALLAS.I, the undersigned, Clerk of the County of Dallas, Texas, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears from the records of said County.WITNESS my hand and the seal of said County, this 1st day of May, 1900.CLERK OF COUNTY.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
13516
CERTIFICATE OF DEATH 14854

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 11yr5mth28dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mathilde Middle G. Last Bollman		4. DATE OF DEATH Month December Day 20 Year 19 61	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 13, 1878
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) nurse		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME August Bollman		14. MOTHER'S MAIDEN NAME Caroline Grimmer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 493X IMMEDIATE CAUSE (a) Heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Pneumonia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Decubitus ulcers			
INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from June 21, 1959 to December 20, 1961 that (I) (we) last saw the deceased alive on Dec. 20, 1961 , and that death occurred at 5:30 M, from the causes and on the date stated above.			
22a. SIGNATURE Stella Wachslar M.D.		22b. DATE SIGNED 12-20-61	
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1-13-62	
23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d. LOCATION (City, town, or county) (State) Pikesville, Md	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street, Zone 2		25a. REC'D BY REGISTRAR DATE JAN 15 '62	
25b. REGISTRAR'S SIGNATURE Arthur L. Hanna			

STATE OF NEW YORK

1912

IN SENATE

JANUARY 1, 1912

REPORT

OF THE

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OF THE

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FOR THE

YEAR 1911

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THE STATE

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13489

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN lb <u>8 yrs.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Catonsville</u> d. STREET ADDRESS <u>2027 Old Frederick Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>HURST</u> Last <u>BOWEN</u>		4. DATE OF DEATH Month <u>December</u> Day <u>19</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Sept 22 1870</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>clerical</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>phonograph</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>JOHN L. BOWEN</u>		14. MOTHER'S MAIDEN NAME <u>MARY VIRGINIA HILLIPS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>VIRGINIA WHEELEY</u> Address <u>2027 Old Frederick Rd. Catonsville, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary fibrosis + emphysema</u> DUE TO <u>422.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerotic cardiovascular disease</u> DUE TO _____ (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>7-20</u> 19 <u>61</u> to <u>present</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>12-13</u> 19 <u>61</u> , and that death occurred at <u>5:30 P</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>John M. Gerwig Jr.</u> M.D.		22b. DATE SIGNED <u>12-19-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN M. GERWIG JR.</u>		22d. ADDRESS <u>400 Graham Rd Baltimore Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 22, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		23d. LOCATION (City, town, or county) <u>Woodlawn, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Farley Coonagh Fun Home, 6601 Frederick Avenue, Catonsville, Md.</u>		25a. REC'D BY REGISTRAR <u>DATE DEC 27 '61</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>	

MEDICAL CERTIFICATION

1918

CERTIFICATE OF DEATH

1918

John H. West

John H. West

John H. West

John H. West

John H. West

John H. West

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John H. West

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it is to be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13512

CERTIFICATE OF DEATH

13490

Item 14 File G304 1/2/62 iwk

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Sharon Drive Rt. 1 Box 590</u>		d. STREET ADDRESS <u>Sharon Drive Rt 1 Box 590</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>C.</u> Last <u>Brodt</u>		4. DATE OF DEATH Month <u>12</u> Day <u>24</u> Year <u>1961</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-23-1874</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Matthias</u>		14. MOTHER'S MAIDEN NAME <u>Rachel unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give number or dates of service)	
17. INFORMANT <u>Address</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Gastro Intestinal Hemorrhage</u> <u>151X</u> DUE TO (b) <u>Carcinoma - Gastric</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Arterio Sclerosis</u> <u>Sensitivity</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u> </u> <u> </u> <u>19</u>	
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town)		20f. (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 18, 1961</u> to <u>Dec. 24, 1961</u> , that (I) (we) last saw the deceased alive on <u>Dec. 24, 1961</u> , and that death occurred at <u>10:00 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>William A. Tyson</u> M.D.		22b. DATE SIGNED <u>12-26-61</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>Kingsville Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>12/27/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		25. ADDRESS <u>5305 Harford Rd.</u>	
26. REC'D BY REGISTRAR <u>DEC 27 61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13513

CERTIFICATE OF DEATH

13491

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY in 1b 156 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE Maryland Worcester c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Snow Hill d. STREET ADDRESS Route #2 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CLARENCE E. BROMLEY			4. DATE OF DEATH December 18 1961				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH December 1, 1892		9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months 12 Days 18 Hours 18 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Truck-farming		11. BIRTHPLACE (County & State, or foreign country) Snow Hill, Maryland			
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME John Bromley			14. MOTHER'S MAIDEN NAME Belle Ellis				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I 220-26-8828		17. INFORMATION Clinical Records, VAH, Baltimore 18, Maryland Fort Howard Division			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARCINOMA, RIGHT LACRIMAL GLAND WITH METASTASIS (b) 191.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 1. Diabetes Mellitus 2. Pyelonephritis 3. Arteriosclerosis, generalized 4. Arteriosclerotic Cardiovascular Disease					INTERVAL BETWEEN ONSET AND DEATH 8 Months		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 15, 1961 , to December 18, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 12/18 , 19 61 , and that death occurred at 9:12 A.M. , from the causes and on the date stated above.							
22a. SIGNATURE Irving Freeman		22b. DATE SIGNED 12/18/61		22c. PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D., Chief, Medical Service, VAH, BALTO. 18, MD., FT. HOWARD DIVISION			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec 29/1961		23c. NAME OF CEMETERY OR CREMATORY Bates Methodist Cemetery			
23d. LOCATION (City, town or county) (State) Snow Hill Maryland		24. FUNERAL DIRECTOR'S SIGNATURE James S. Thomas					
25a. REC'D BY REGISTRAR DEC 22 '61		25b. REGISTRAR'S SIGNATURE James S. Thomas					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO: DIRECTOR, FBI
FROM: SAC, NEW YORK
SUBJECT: [Illegible]
RE: [Illegible]
[Illegible text block containing several lines of typed communication]

[Illegible text block containing several lines of typed communication, including a date stamp and a signature area]

Item 18 Form 303 12-26-61
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
13514
13492

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN lb 42 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Virginia b. COUNTY Alexandria c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) P3X-3 d. STREET ADDRESS 204 Northview Terrace e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM HILL BROOKE		4. DATE OF DEATH Month December Day 2 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 14, 1891
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (County & State, or foreign country) Richmond County, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Roderick B. Brooke		14. MOTHER'S MAIDEN NAME Ella C. Harrison	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW-1		16. SOCIAL SECURITY NO. WW-1	
17. INFORMANT Clin Rec VAH Baltimore Md - Ft Howard Division		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA INFARCTION DUE TO LEFT CORONARY OCCLUSION (b) PULMONARY INFARCT CHRONIC CYSTITIS WITH DUE TO PEYELONEPHRITIS (c) CORONARY THROMBOSIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) BRONCHOPNEUMONIA Escherichia Coli Septicemia CARCINOMA OF TESTES METASTASIS TO LIVER			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this physician) attended the deceased from Oct. 21, 19 61 to Dec. 2, 19 61 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Dec. 2, 19 61 , and that death occurred at 9:35 p.m. from the causes and on the date stated above.			
22a. SIGNATURE R. N. Lee M.D.		22b. DATE SIGNED 12-3-61	
22c. PHYSICIAN'S NAME (Type) Ralph N. Lee M.D.		22d. ADDRESS VAH Baltimore 18 Md - Ft Howard Division	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/5/61	23c. NAME OF CEMETERY OR CREMATORY National Memorial Cemetery	23d. LOCATION (City, town or county) (State) FALLS CHURCH VIRGINIA
24 FUNERAL DIRECTOR'S SIGNATURE William Demain & Son		25a. REC'D BY REGISTRAR DATE DEC 5 '61	25b. REGISTRAR'S SIGNATURE Arthur L. Knaus

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 must be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **13493**

13515

FOR STATE
HEALTH DEPT.

M

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 15 Bond Avenue			d. STREET ADDRESS 15 Bond Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Eugene Middle Thomas Last Brown			4. DATE OF DEATH Month December Day 16 Year 19 61		
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 16, 1874		9. AGE (In years last birthday) 87 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Carroll Co., Maryland	
13. FATHER'S NAME Thomas Brown			14. MOTHER'S MAIDEN NAME Alice Ross		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Alice Young - Box 290, Earleigh Heights, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic C-V Disease 260 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 5 yrs. 5 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none			
20c. TIME OF INJURY Month, Day, Year Hour a. m. none p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none	
		20f. (City or town) Reisterstown		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE D. D. Caples		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12-18-61	
EXAMINER'S NAME (Type) D. D. Caples, M. D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-20-61		22c. NAME OF CEMETERY OR CREMATORY St. Lukes Church	
				22d. LOCATION (City, town, or county) Reisterstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law			ADDRESS 802 Madison Ave., Balto., Md.		24a. REC'D BY REGISTRAR DEC 19 '61
					24b. REGISTRAR'S SIGNATURE Charles R. Law

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 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13516

CERTIFICATE OF DEATH

13494

1. PLACE OF DEATH a. COUNTY <i>Balto.</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Balto.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lutherville</i>				c. LENGTH OF STAY IN 1b <i>50 yrs</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1428 Railroad Ave.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>SUSIE L. BROWN</i>				4. DATE OF DEATH <i>12/31/61</i> 19 <i>61</i>			
5. SEX <i>F</i>		6. COLOR OR RACE <i>negro</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Oct. 16, 1874</i>	
9. AGE (In years lost birthday) <i>87</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		11. BIRTHPLACE (State or foreign country) <i>md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. H</i>	
13. FATHER'S NAME <i>Wm. H. Brown</i>				14. MOTHER'S MAIDEN NAME <i>Elizabeth Johnson</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Marie Jackson - Lutherville, Md.</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Carcinoma</i> DUE TO <i>Carcinoma of Large Bowel</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>2 yrs</i> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <i>1 yr</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <i>October 1947</i> to <i>Dec 31, 1961</i> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <i>Dec 30, 1961</i> , and that death occurred at <i>7 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Charles F. O'Donnell</i> M.D.				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <i>Charles F. O'Donnell</i>	
22d. ADDRESS <i>7501 York Rd. #4 Md 11/2/62</i>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>1/4/62</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Pleasant Rest</i>		23d. LOCATION (City, town, or county) (State) <i>Towson, Balto. Co. Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. J. Chaturman Jr - 1701 McCulloch St. Balto. Md.</i>				25a. REC'D BY REGISTRAR <i>Jan 4 '62</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

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TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13517

13495

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural-White Hall</u> c. LENGTH OF STAY IN 1b <u>72 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Graystone Rd.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural-White Hall</u> d. STREET ADDRESS <u>Graystone Rd.</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Florence H. Burns</u>		4. DATE OF DEATH Month <u>December</u> Day <u>29</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 26, 1871</u>
9. AGE (In years last birthday) <u>90</u>		10. IF UNDER 1 YEAR: Months <u>1</u> Days <u>10</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Parkton, Md.-R.D.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Darby A. Foster</u>		14. MOTHER'S MAIDEN NAME <u>Mary A. Vance</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Edna J. Burns, White Hall Md. R.D.</u>		Address <u>White Hall Md. R.D.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerosis</u> DUE TO (c) <u>10 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1952</u> to <u>Dec 29, 1961</u> that (I) (we) last saw the deceased alive on <u>Dec 29, 1961</u> , and that death occurred <u>3:35 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Milner Bortner M.D.</u>		22b. DATE SIGNED <u>12/29/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Milner Bortner</u>		22d. ADDRESS <u>White Hall, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Jan. 1, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Wiseburg Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>White Hall, Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hertenstein, New Freedom, Pa.</u>		25. REC'D BY REGISTRAR <u>—</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	
DATE <u>JAN 4 '62</u>			

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13496

1. PLACE OF DEATH a. COUNTY BALTO MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY BALTO	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HALETHORPE		c. LENGTH OF STAY IN 1b 30 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4304 WASHINGTON ST		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BERTHA ALBERTA CAGER		4. DATE OF DEATH Month 12 Day 9 Year 1961	
5. SEX FEMALE	6. COLOR OR RACE C/PO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/30/1905
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months 5 Days 6 Hours 56 Min.	IF UNDER 24 HRS. Months 5 Days 6 Hours 56 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC		10b. KIND OF BUSINESS OR INDUSTRY PUT FAMILY	11. BIRTHPLACE (State or foreign country) CALVERT CO MD
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Gross	
14. MOTHER'S MAIDEN NAME ALBERTA RAWLINGS		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. 219-28-7368 HA		17. INFORMANT WALTER CAGER Address 4304 WASHINGTON ST	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO HYPERTENSION, ARTEROSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) LOBAR PNEUMONIA DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 DAY	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1 Dec 1961 to 2 Dec 1961 , that (I) (we) last saw the deceased alive on 2 Dec 1961 , and that death occurred at 12:30 M, from the causes and on the date stated above.			
22a. SIGNATURE George E. Shalean M.D.		22b. DATE SIGNED 10 Dec 61	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE THEREOF 12/13/61	
23c. NAME OF CEMETERY OR CREMATORY Ortobus		23d. LOCATION (City, town, or county) (State) Ortobus - Balt. Co. Md	
24. FUNERAL DIRECTOR'S SIGNATURE Marlene P. Hays ADDRESS 638 N. G. & MOR ST		25a. REC'D BY REGISTRAR DATE DEC 11 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Hays			

Received of
 Messrs. J. & W. G. & Co.
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Page 13

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13519

CERTIFICATE OF DEATH

13497

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN b 5 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Trappe d. STREET ADDRESS Route #1 Box 64A e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) LEVIN R CAMPER			4. DATE OF DEATH Month Day Year December 3 19 61		
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH May 21, 1888		9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer			10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (County & State, or foreign country) Trappe, Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME Levin H. Camper		
14. MOTHER'S MAIDEN NAME Georgette Trippe			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		
16. SOCIAL SECURITY NO. WW I			17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland FORT HOWARD DIVISION		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) CARCINOMA OF AMPULLA OF VATER WITH METASTASES TO LIVER AND LUNGS BRONCHOPNEUMONIA Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) DOX (c) DUE TO					INTERVAL BETWEEN ONSET AND DEATH UNKNOWN TERMINAL
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that to (this hospital) attended the deceased from November 28, 1961 to December 3, 1961 that to (we) last saw the deceased alive on December 3, 1961 , and that death occurred at 8:30 P.M. from the causes and on the date stated above.					
22a. SIGNATURE <i>Sebastian Russo</i>		22b. DATE SIGNED 12/4/61		22c. PHYSICIAN'S NAME (Type) SEBASTIAN RUSSO, M.D.	
22d. ADDRESS VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-8-61		23c. NAME OF CEMETERY OR CREMATORY Trappe Cemetery	
23d. LOCATION (City, town or county) Trappe		(State) Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Elroy O. Wilson, 1000 Brantley Ave., Balto. 17, Md.		25a. REC'D BY REGISTRAR DEC 6 '61		25b. REGISTRAR'S SIGNATURE <i>Charles S. Russo</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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ON 10/10/10
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FOR STATE
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, it should be executed by the funeral director. Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13521

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13499

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>9321 Old Harford Road</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> d. STREET ADDRESS <u>9321 Old Harford Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mrs. Mary Jane Carroll</u>		4. DATE OF DEATH Month <u>December</u> Day <u>6</u> Year <u>1961</u>		5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 25, 1880</u>		9. AGE (in years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David Sindell</u>		14. MOTHER'S MAIDEN NAME <u>Carolina Sacrum</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs. Lillian De Baugh</u>		Address <u>same.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u> </u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <u>John C. Hyle</u> ASSISTANT MEDICAL EXAMINER <u> </u> DEPUTY MEDICAL EXAMINER <u> </u> DATE SIGNED <u>12-7-61</u> Address (Street, city, town, or county) <u>7527 Belair Rd.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/9/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Road #14</u>		24a. REC'D BY REGISTRAR <u>DEC 8 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

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HEALTH DEPT.
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Middle River - Md</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Middlesex</u>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <u>732 Corby Road</u>	
4. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>P.A. RR. Tracks</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Lindy Chaney, Jr.</u>		4. DATE OF DEATH Month Day Year <u>Dec 23 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 1, 1947</u>
9. AGE (In years last birthday) <u>14</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Charles Lindy Chaney, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Anna Elizabeth Nadreau</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mr. Frederick M. Wood, Sr. - 4817 Wilein Ave.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Compound Fractures -</u> 802 X DUE TO (b) <u>(Skull, Femurs; Ankles; Large Lac.)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Left Lumbar Injury @ Evisceration</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Struck by P.A. RR TR # 148 - Engine # 4870 - N. Bound.</u>	
20c. TIME OF INJURY <u>12:45</u> p.m. <u>12/23/61</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>P.A. RR. Tr.</u>	20f. (City or town) (County) (State) <u>Middle River - Balt - Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>M.B. Davis</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M.B. Davis MD</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u>12/23/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-28-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>	22d. LOCATION (City, town, or country) (State) <u>Bel Air, Maryland</u>
23. FUNERAL DIRECTOR <u>Wm J. Zickler & Sons</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thane</u>	
ADDRESS <u>Balt. Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 28 '61</u>	

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TERMINAL OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13524

CERTIFICATE OF DEATH

Reg. Dist. No. 13502

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Batonville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in Pines</u>		d. STREET ADDRESS <u>5419 Merle Drive</u>	
3. NAME OF DECEASED (Type or print) <u>GRODIE</u> First <u>CHAZEN</u> Middle Last		4. DATE OF DEATH <u>12-7-1961</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>70</u> yrs. 9. AGE (In years last birthday) <u>70</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Russian</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Solomon</u>		14. MOTHER'S MAIDEN NAME <u>Yetta</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Bessie Stein - Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422</u> DUE TO <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic C.V.D.</u> DUE TO (c) <u>Diabetes mellitus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>10 yrs.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/27</u> , 19 <u>60</u> , to <u>12/7</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>12/6</u> , 19 <u>61</u> , and that death occurred at <u>12:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Temple Gardens Apt. Baltimore 17, Md.</u> DATE SIGNED <u>Dec. 7, 1961</u>			
ACTUAL SIGNATURE <u>A. A. Silver</u> M.D.		PHYSICIAN'S NAME (Type) <u>A. A. Silver, M. D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-8-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt Carmel</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u> ADDRESS <u>2100 Eastern Place</u>		24a. REC'D BY REGISTRAR <u>DEC 8 '61</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>			

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13503

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1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6726 Fifth Avenue		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK d. STREET ADDRESS 6726 Fifth Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle CHESNEY Last Female White Garment Worker		4. DATE OF DEATH Month 12 Day 15 Year 1961 June 4, 1892 69 yrs. U.S.A.	
5. SEX Female White Garment Worker		6. COLOR OR RACE White Garment Worker	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. BIRTHPLACE (State or foreign country) Brunswick, Maryland U.S.A.	
9. FATHER'S NAME William W. Doll		10. MOTHER'S MAIDEN NAME Adelia Thomas	
11. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		12. SOCIAL SECURITY NO. 215-28-5429-A	
13. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY ARTERY THROMBOSIS 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)		14. INTERVAL BETWEEN ONSET AND DEATH 	
15. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		16. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
17. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		18. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
19. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
21. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		22. (City or town) (County) (State)	
23. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
24. ACTUAL SIGNATURE EXAMINER'S NAME (Type) DATE SIGNED R.S. Fisher 12-16-61 CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)			
25. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		26. DATE THEREOF 12-19-61	
27. NAME OF CEMETERY OR CREMATORY Baltimore National		28. LOCATION (City, town, or country) (State) Baltimore	
29. FUNERAL DIRECTOR Wm. Cook, Inc., 1217 St. Paul Street, Zone 2		30. REC'D BY REGISTRAR DATE DEC 20 '61	
31. REGISTRAR'S SIGNATURE Arthur S. Thomas			

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Page 4
TO HOSPITAL OR A MENTAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the deceased was retained by a hospital or attending physician, the law requires that the death certificate be executed within 24 hours after death. If the deceased was retained by a hospital or attending physician, the law requires that the death certificate be executed within 24 hours after death. If the deceased was retained by a hospital or attending physician, the law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
13526
CERTIFICATE OF DEATH
13504

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 23 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frederick Middle T. Last Collier		4. DATE OF DEATH Month December Day 1 Year 1961	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 9, 1907
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY Washington, D. C.	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Richard Collier		14. MOTHER'S MAIDEN NAME Margaret Sullivan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW 2		16. SOCIAL SECURITY NO. 579-09-6098	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO Cardiac disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that this (this hospital) attended the deceased from Nov. 8, 1961 to Dec. 1, 1961 that (I) (we) lost saw the deceased alive on Dec. 1, 1961 , and that death occurred at 7:15 M, from the causes and on the date stated above.			
22a. SIGNATURE Stella Wachslar		22b. DATE SIGNED 12/1/61	
22c. PHYSICIAN'S NAME (Type) Stella Wachslar		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/5/61	
23c. NAME OF CEMETERY OR CREMATORY Arlington Cemetery		23d. LOCATION (City, town, or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey, Bethesda, Maryland		25a. REC'D BY REGISTRAR DEC 6 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. K...			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
13527		13505	
1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)	
a. COUNTY Baltimore		a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		b. COUNTY Baltimore	
c. LENGTH OF STAY IN lb 15 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS 1718 N. Mount Street	
3. NAME OF DECEASED (Type or print) JOE B. COLLINS		4. DATE OF DEATH December 2 19 61	
5. SEX Male		6. COLOR OR RACE Negro	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/12/93	
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11b. KIND OF BUSINESS OR INDUSTRY Construction	
12. BIRTHPLACE (County & State, or foreign country) Charleston, West Virginia		13. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. FATHER'S NAME James Collins		15. MOTHER'S MAIDEN NAME Liza Doyle	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		17. SOCIAL SECURITY NO. 218-10-4639	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. INFORMANT Clinical Records, VAH, Baltimore, Md. Fort Howard Division	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) APLASTIC ANEMIA 757.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) MULTIPLE CYSTS OF THE KIDNEYS DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (he, this hospital) attended the deceased from November 17, 1961 to December 2, 1961 , that (he, we) last saw the deceased alive on December 2, 1961 , and that death occurred at 11:30 am on the causes and on the date stated above.			
22a. SIGNATURE PAUL G. KOUKOULAS, M.D.		22b. DATE SIGNED 12/2/61	
22c. PHYSICIAN'S NAME (Type) PAUL G. KOUKOULAS, M.D.		22d. ADDRESS VAH BALTIMORE, MD. - FT HOWARD DIV.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-8-61	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town or county) (State) Baltimore 28, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Elroy O. Wilson Funeral Home, 2004 Orleans St. Balto. Md.		25a. REC'D BY REGISTRAR DEC 6 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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[Handwritten signature]

14-1-11

Bliss C. Wilson, President, 14-1-11

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13528

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1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			
a. COUNTY Baltimore				a. STATE Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				b. COUNTY Baltimore			
c. LENGTH OF STAY IN 1b 5 years				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 7922 Roldrew Ave.							
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Charles Raymond Connelly Sr.				4. DATE OF DEATH 12-9-61			
5. SEX Male				6. COLOR OR RACE White			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH April 4, 1893			
9. AGE (In years last birthday) 68 yrs.				IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant (Ret)				10b. KIND OF BUSINESS OR INDUSTRY Accounting		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME William John Connelly			
14. MOTHER'S MAIDEN NAME Sarah Kelly				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No			
16. SOCIAL SECURITY NO. 212-20-8250				17. INFORMANT Mr. Charles R. Connelly			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Recurrent coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive-arteriosclerotic Cardio-vascular disease DUE TO (c) 13y				INTERVAL BETWEEN ONSET AND DEATH 3 1/2 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 13y							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Apr. 11, 1947 to Dec 9, 1961 , that (I) (we) last saw the deceased alive on Dec 8, 1961 , and that death occurred at 2 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Fredrick J. Vollmer				22b. DATE SIGNED 12/11/61		22c. PHYSICIAN'S NAME (Type) FREDERICK J. VOLLMER	
22d. ADDRESS 6100 York Rd, Balto-12, Md.				22e. REC'D BY REGISTRAR			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 12-12-61		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	
23d. LOCATION (City, town or county) Parkville, Balt. Ct. Md.				23e. REGISTRAR'S SIGNATURE Henry W. Jenkins & Sons Co			
24. FUNERAL DIRECTOR'S SIGNATURE 4905 York Rd. Baltimore 12, Md.				DATE DEC 13 '61			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Item 18 F-307
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13529 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13529 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13507

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore (6) c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 8200 Pulaski Highway - Trailer Camp				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore (6) d. STREET ADDRESS 8200 Pulaski Highway - Trailer e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARY		First MARY		Middle LEE		Last Cosner	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug 17, 1894	
9. AGE (In years last birthday) 67		IF UNDER 1 YEAR Months 12 Days 10		IF UNDER 24 HRS. Hours 10 Min. 161			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) South Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Unknown Quick				14. MOTHER'S MAIDEN NAME Sarah (Unknown)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. (If yes give war or dates of service) None		17. INFORMANT Walter Wise Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute focal bilateral bronchopneumonia, compli- 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) cating atherosclerotic heart disease DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Peter W. Rieckert				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) PETER W. RIECKERT, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED 12-11-61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 12, 1961		22c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		22d. LOCATION (City, town, or country) (State) Balto Md.	
23. FUNERAL DIRECTOR Sassah Funeral Home				24a. REC'D BY REGISTRAR DEC 14 '61			
24b. REGISTRAR'S SIGNATURE Arthur S. Hanna							

VS. ATISME
5M 9/60

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Pages 1, 2, and 3 to this funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

12307

12325



[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page.]

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MEDICAL CERTIFICATION	1. PLACE OF DEATH a. COUNTY Baltimore	2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland	b. COUNTY ✓					
	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	c. LENGTH OF STAY IN 1b 4mth16dys	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	d. STREET ADDRESS 2705 Oswego Avenue				
	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	4. DATE OF DEATH Month December	Day 1	Year 19 61			
	3. NAME OF DECEASED (Type or print) Virginia I. Cox	First Virginia	Middle I.	Last Cox	6. DATE OF BIRTH Month May	Day 3,	Year 1895	
	5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months 66	Days 66	IF UNDER 24 HRS. Hours 66	Min. 66
	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Virginia	12. CITIZEN OF WHAT COUNTRY? U. S. A.	13. FATHER'S NAME George Falls	14. MOTHER'S MAIDEN NAME Irene Brooks		
	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown	16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Lucille Smith	Address Records: SPRING GROVE STATE HOSPITAL	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerotic heart disease DUE TO (c) Generalized arteriosclerosis	INTERVAL BETWEEN ONSET AND DEATH		
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pt. fell to floor on 10-11-61 sustaining an intertrochanteric fracture of the right femur.	20c. TIME OF INJURY Month, Day, Year 3:45 p.m. 10-11 1961	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) hospital	20f. (City or town) (County) (State) Catonsville 28, Maryland
	21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	CHIEF MEDICAL EXAMINER <input type="checkbox"/>	22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/4/61	22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	22d. LOCATION (City, town, or country) (State) Baltimore, Maryland		
	23. EXAMINER'S NAME (Type) George M. Kieffer, M.D.	24a. REC'D BY REGISTRAR DEC 4 '61	24b. REGISTRAR'S SIGNATURE Edson	DATE SIGNED 12-1-61				

1330

1330

M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
13531						13509							
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Relay c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 5169 Gundry Lane						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Relay d. STREET ADDRESS 5169 Gundry Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First John Middle N. Last Crook						4. DATE OF DEATH Month Dec. Day 2, Year 1961							
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 29, 1915		9. AGE (In years last birthday) 46 yrs.		10. IF UNDER 1 YEAR Months 4 Days 1 Hours 1 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) machinist				10b. KIND OF BUSINESS OR INDUSTRY Calvert Dist. Maryland				11. BIRTHPLACE (County & State, or foreign country) U. S. A.					
13. FATHER'S NAME George G. Crook						14. MOTHER'S MAIDEN NAME Nellie B. Berrett							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes WWII						16. SOCIAL SECURITY NO. 215-01-8876						17. INFORMANT Mary Eleanor Crook, 5169 Gundry La. #29	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Acute Myocardial Infarction Conditions, if any, which gave rise to immediate cause (b) 420.1 DUE TO Acute Myocardial Infarction (c) 420.1 DUE TO Acute Myocardial Infarction PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420.1 DUE TO Acute Myocardial Infarction INTERVAL BETWEEN ONSET AND DEATH 420.1													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour 19 e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) December 2		20f. (City or town) December 2		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from December 2, 1961 to December 2, 1961 , that (I) (we) last saw the deceased alive on December 2, 1961 , and that death occurred at 4:30 A.M. from the causes and on the date stated above.													
22a. SIGNATURE John E. Healey 22c. PHYSICIAN'S NAME (Type) John Healey, M. D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Francis Ave.		22b. DATE SIGNED					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/5/61		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem. Baltimore, Md.				23d. LOCATION (City, town or county) (State)					
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard						ADDRESS 4107 Wilkens Ave. #29		25a. REC'D BY REGISTRAR DEC 5 '61		25b. REGISTRAR'S SIGNATURE Charles S. Kraus			

M

Baltimore

Relay

5109 Gandy Lane

John

male white

machine

George C. Grover

Will

No.

Relay

5109 Gandy Lane

% Grook

Oct. 2, 1910

Calverly Dist., Maryland

Nellie E. Bennett

215-01 Mary Eleanor Grook, 5109 Gandy Lane

December 2

December 2

Dec. 2

Francis Ave.

John Healey, N. D.

Baltimore National Cam. Baltimore, Md.

12/2/10

Howard H. Hubbard 4107 Wilkens Ave. #22

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **13510**

13532

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk			c. LENGTH OF STAY IN 1b 7 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Res., 8029 Del Haven Road				d. STREET ADDRESS 8029 Del Haven Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Gertrude Middle Cross Last Cross				4. DATE OF DEATH Month Dec. Day 22, Year 19 61			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Oct. 20, 1882	9. AGE (In years last birthday) yrs. 79	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired, Nurse			10b. KIND OF BUSINESS OR INDUSTRY Connecticut		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Daniel Jones				14. MOTHER'S MAIDEN NAME Mary E. Doty			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ----		17. INFORMANT Address Mrs. Mary Margaret Rodearmel 8029 Del Hav			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A-S-C-V-DISEASE 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 12 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 18, 1961 to Dec 22, 1961 that I last saw the deceased alive on Dec 18, 1961 and that death occurred at 3:25 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Melvin B. Davis				ADDRESS (Street, city or town, state) 6800 Moxam Rd. Dundalk, Md.			
PHYSICIAN'S NAME (Type) Melvin B. Davis, M.D.				DATE SIGNED Dec 22 12/22/61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-23-1961		22c. NAME OF CEMETERY OR CREMATORY Mt. Carmel		22d. LOCATION (City, town, or county) (State) O'Donnell St. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN J. DUDA				ADDRESS 7922 Wise Ave. 22, Md.		24a. REC'D BY REGISTRAR DEC 28 61	
24b. REGISTRAR'S SIGNATURE				24c. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13533

CERTIFICATE OF DEATH

13511

1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				c. LENGTH OF STAY IN 1b 3001-4			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Shady Nook Nursing Home-1001 N. Rolling Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Myrtle R. Curtis				4. DATE OF DEATH Month Day Year December 22, 1961 19			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 2, 1887		9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired (Librarian)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME William Robertson				
14. MOTHER'S MAIDEN NAME Clara Tabb			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				
16. SOCIAL SECURITY NO.			17. INFORMANT Mrs. Gertrude B. Wood-401 Woodlawn Road				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 157X IMMEDIATE CAUSE (a) Carcinoma of Pancreas DUE TO (b) Broncho-pneumonia DUE TO (c) Generalized Arterio Sclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). Generalized Arterio Sclerosis							INTERVAL BETWEEN ONSET AND DEATH 3 weeks 4 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Tune 30, 1961 to Dec 22, 1961 , that (I) (we) last saw the deceased alive on Dec 21, 1961 , and that death occurred at 1118 St. Paul St. from the causes and on the date stated above.							
22a. SIGNATURE Wetherbee Fort				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) Wetherbee Fort	
22d. ADDRESS 1118 St. Paul St.		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-23-61		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Jackson				24b. ADDRESS Baltimore, Md.		25a. REC'D BY REGISTRAR DEC 26 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus				25c. DATE DEC 26 '61			

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1951

1951

REGISTER & SIGNATURE
Arthur L. Krauss

VR A15 (4)
15M 9/60

4554

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13535						13513					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY			BALTO			a. STATE			MD		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			CATONSVILLE			b. COUNTY			BALTO.		
c. LENGTH OF STAY IN 1b						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			CATONSVILLE		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
1 S. T. PROSPECT AVE						1 S. T. PROSPECT AVE					
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH			5. AGE (In years last birthday)		
ANTHONY D'ALFONZO						12/26			77 yrs.		
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
m		w		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8/4/84		77 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY?	
merchant				ret.		Italy				U.S.	
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
Salvatore D'Alfonzo						Battalini					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address					
no						Vincent D'Alfonzo					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 433.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)										48 hrs. 5 yrs?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
19								Jan. 14, 1957		Dec. 26, 1961	
21. I certify that (I) (this hospital) attended the deceased from Jan. 14, 1957 to Dec. 26, 1961, that (I) (we) last saw the deceased alive on Dec 25, 1961, and that death occurred at 9:31 AM, from the causes and on the date stated above.											
22a. SIGNATURE						ATTENDING PHYS. <input checked="" type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
George E. Urban						M.D.			Dec 26, 1961		
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
George E. URBAN						805 Frederick Ave 28 Md					
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
BURIAL				12/29/61		LORRAINE		BALTO. CO. MD.			
24. FUNERAL DIRECTOR'S SIGNATURE						ADDRESS			25a. REC'D BY REGISTRAR		
Mac Nabbs & Son						28			DATE JAN 2 '62		
									25b. REGISTRAR'S SIGNATURE		
									Arthur S. Thomas		



13533

13518

[Faint, illegible handwriting, possibly a list or notes.]

[Faint, illegible handwriting, possibly a list or notes.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13536
CERTIFICATE OF DEATH
13514

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 604 Allegheny Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CARRIE OLD DANCE				4. DATE OF DEATH Month December Day 31 , Year 19 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 10, 1881	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Robert E. Old				14. MOTHER'S MAIDEN NAME Sarah Vermillion			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT G. Willard Dance, Towson, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADENOCARCINOMA OF CERVIX 171X Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. (c) DUE TO DUE TO DUE TO				INTERVAL BETWEEN ONSET AND DEATH 4 YRS +			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) GENERALIZED ARTERIOSCLEROSIS, DIABETES MELLITUS				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/22 , 19 55 to 12/31 , 19 61 , that (I) (was) last saw the deceased alive on 12/30 , 19 61 , and that death occurred at 9 AM , from the causes and on the date stated above.							
22a. SIGNATURE T. C. Siwinski				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) T. C. Siwinski, M.D.				22d. ADDRESS 206 W. Pennsylvania Avenue, Towson 4, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 2, 1962		23c. NAME OF CEMETERY OR CREMATORY Waugh Chapel Cemetery		23d. LOCATION (City, town or county) (State) Greenwood, Balto. Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland				25a. REC'D BY REGISTRAR DATE JAN 3 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	



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Town

101 Albany Avenue

CAROL ANN WACE

101 Albany Avenue

Town

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13537 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 8 Film G302 12/13/61 iwk

Reg. Dist. No. 13515

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Catonsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>115 Bloomsbury Ave</u>		d. STREET ADDRESS <u>115 Bloomsbury Ave</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Madge Marie Daugherty</u>		4. DATE OF DEATH Month Day Year <u>Dec. 8, 1961</u> 19	
5. SEX <u>Fem.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 8, 1911</u>
9. AGE (In years last birthday) <u>50</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>W Va</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Guy Carpenter</u>		14. MOTHER'S MAIDEN NAME <u>? Plymate</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Carl Daugherty</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis (accident)</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Geo. S. M. Kieffer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Geo. S. M. Kieffer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		1010 Leeds Ave. Dec. 8, 61	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/11/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Old Fellows</u>		22d. LOCATION (City, town, or county) (State) <u>Richmond W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Mott + Son Catonsville</u>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <u>DEC 11 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate stating the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be retained for the Medical Examiner's Office along with form PM3. Page 5 may be retained for the funeral director. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
13538						13516						
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)						
a. COUNTY			Baltimore			a. STATE			Md.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			Baltimore			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			XXXX none			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
1110 Elm Road						435 S. Bentalou St.						
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH			5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Joseph H. Davidson						Dec. 15, 1961						
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR		
male		white		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Aug. 25, 1878		83 yrs.		Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY?		
Grave Digger				Retired		Baltimore, Md.				XXX U. S.A.		
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME						
Unknown Davidson						Unknown						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)						17. INFORMANT Address (son)						
no						216 07 0377 Frank J. Davidson 1110 Elm Rd. #27						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Hypertensive Cardio-Vascular disease												
443X DUE TO												
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)												
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m.						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
19												
21. I certify that (I) (the hospital) attended the deceased from Dec. 15, 1961, to Dec. 15, 1961, that (I) (we) last saw the deceased alive on Dec. 15, 1961, and that death occurred at 9:00 M. from the causes and on the date stated above.												
22a. SIGNATURE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED			
Joseph Liberto, M.D.						3508 Bank St.			12/15/61			
23a. BURIAL, CREMATION, REMOVAL (Specify)						23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)		
Burial						12/18/61		Loudon Park Cemetery		Baltimore, Md.		
24 FUNERAL DIRECTOR'S SIGNATURE						ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Howard H. Hubbard						4107 Wilkens Avenue			DATE DEC 19 '61		Arthur S. Thomas	

VR A15 (4)
15M 9/60



1853

1853

Baltimore

Baltimore

105 S. Baltimore St.

111 S. Bond

Joseph P. Davidson

1000

Aug. 25, 1853

Aug. 25, 1853

Grave Digging

Baltimore

Unknown

Unknown

105 S. Baltimore St. Baltimore Md.

Hydroneuritis

Aug 12 1853

Aug 12 1853

Joseph P. Davidson

105 S. Baltimore St.

105 S. Baltimore St.

Baltimore

Howard M. Hubbard #107 Wilkens Avenue

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 are retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13539						13517					
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills c. LENGTH OF STAY IN lb 3 mos. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rosewood State Training School						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 734 West Fayette Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Andrew James Davis						4. DATE OF DEATH Month 12 Day 14 Year 19 61					
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/5/46		9. AGE (In years last birthday) 15 yrs.		IF UNDER 1 YEAR Months 12 Days 14 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dependent				10b. KIND OF BUSINESS OR INDUSTRY none				11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Ivory Davis						14. MOTHER'S MAIDEN NAME Gertrude Davis					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no						16. SOCIAL SECURITY NO. ---					
17. INFORMANT Rosewood Records, Owings Mills, Md.						Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 491X IMMEDIATE CAUSE (a) Bilateral broncho-pneumonia DUE TO (b) and metastatic cerebral abscess. Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. complicating microcephaly. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Microcephaly with quadriplegia Birth INTERVAL BETWEEN ONSET AND DEATH 7 days - 4 days -											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore		20g. (County) Baltimore		20h. (State) Md.	
21. I certify that (H) (this hospital) attended the deceased from 9/11 to 12/14 , 19 61 , that (H) (we) last saw the deceased alive on 12/14 , 19 61 , and that death occurred at 8:55 a.m. on the causes and on the date stated above.											
22a. SIGNATURE Harry G. Butler 22c. PHYSICIAN'S NAME (Type) Harry G. Butler, M.D.						22b. DATE SIGNED 12/15/61 ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS Rosewood Lane, Owings Mills, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 12/18/61		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn		23d. LOCATION (City, town, or county) Baltimore, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Charles A. Rice						ADDRESS 661 W. Bore St		25a. REC'D BY REGISTRAR DEC 20 '61		25b. REGISTRAR'S SIGNATURE Charles A. Rice	



02761

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13540

13518

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lutherville 4</u> c. LENGTH OF STAY in 1b <u>Sept 1-61</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>College Manor</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u> d. STREET ADDRESS <u>apt 328-3500-14 St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) <u>Mary Ellen De Atley</u>		4. DATE OF DEATH <u>8 am</u> <u>12</u> <u>14</u> <u>1961</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-23-1890</u> <u>70</u> yrs.		9. AGE (In years last birthday) <u>70</u>		IF UNDER 1 YEAR Months <u>11</u> Days <u>14</u>		IF UNDER 24 HRS. Hours <u>11</u> Min. <u>14</u>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Washington D.C.</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Washington D.C.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>											
13. FATHER'S NAME <u>Millard F. Coxen</u>								14. MOTHER'S MAIDEN NAME <u>Julia Robey</u>															
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>								16. SOCIAL SECURITY NO. <u>no</u>								17. INFORMANT <u>M.B. Miller R.N. College Manor</u> <u>Lutherville Md.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Degeneration</u> DUE TO <u>Due to Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Cerebral arteriosclerosis</u> DUE TO <u>Arteriosclerosis</u>																INTERVAL BETWEEN ONSET AND DEATH <u>330X</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)																							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 1, 1961</u> to <u>Dec 14, 1961</u> , that (I) (we) last saw the deceased alive on <u>Dec 14, 1961</u> , and that death occurred at <u>9 AM</u> , from the causes and on the date stated above.																							
22a. SIGNATURE <u>M Paul Byerly</u> M.D.										ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED									
22c. PHYSICIAN'S NAME (Type) <u>M Paul Byerly</u>										22d. ADDRESS <u>5420 York Rd Bldg 12</u>													
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>12-18-61</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Washington Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Washington D.C.</u>											
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tickner & Sons</u> <u>Balto. Md.</u>																							
25a. DEC'D BY REGISTRAR <u>DEC 18 '61</u>										25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>													

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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(10)

(1)

THE UNIVERSITY OF CHICAGO
LIBRARY
CHICAGO, ILL.
JAN 10 1964

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please
explain the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4
should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1354 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13519

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8671 Oak Road		d. STREET ADDRESS 8671 Oak Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Milton W. Dennis		4. DATE OF DEATH Dec 18 19 61	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-18-1898
9. AGE (In years last birthday) 63 yrs.		10. FUNDING YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gas Co.		10b. KIND OF BUSINESS OR INDUSTRY Retired Gas & Elec.	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME August Dennis		14. MOTHER'S MAIDEN NAME Lola Emory	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, never unknown) (If yes, give war or dates of service) Yes Army		16. SOCIAL SECURITY NO. 212-05-4233	
17. INFORMANT Mrs Elsie Dennis		Address 8671 Oak Road (14)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic Cardiovascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) INTERVAL BETWEEN ONSET AND DEATH immed undet			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John C. Hyle		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) John C Hyle		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-23-1961	
22c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Mem. Gardens		22d. LOCATION (City, town, or county) (State) Timonium Md	
23. FUNERAL DIRECTOR'S SIGNATURE Lessaht Fumad		ADDRESS 7401 Belair Road	
24a. REC'D BY REGISTRAR DEC 20 '61		24b. REGISTRAR'S SIGNATURE William S. Kraus	

FOR STATE
HEALTH DEPT.

W

1. Name of deceased
2. Sex
3. Age
4. Date of death
5. Place of death
6. Cause of death
7. Signature of physician
8. Signature of medical examiner
9. Signature of coroner
10. Signature of registrar

1934 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

1. Name of deceased
2. Sex
3. Age
4. Date of death
5. Place of death
6. Cause of death
7. Signature of physician
8. Signature of medical examiner
9. Signature of coroner
10. Signature of registrar

CERTIFICATE OF DEATH

Reg. Dist. No. 13520

13542

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn				c. LENGTH OF STAY IN 1b 20yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1916 Summit Ave.				d. STREET ADDRESS 1916 Summit Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Nellie E. Derreth				4. DATE OF DEATH Month Dec. Day 27 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 9, 1894	
9. AGE (In years lost birthday) yrs. 67		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME George Emich				14. MOTHER'S MAIDEN NAME Alice Emich (?)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT William E. Derreth Sr. Address 1916 Summit Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant Lymphoma DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 20002 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH pos 24h							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from June 1951 to Dec 27, 1961 , that I last saw the deceased alive on Dec 6, 1961 , and that death occurred at 8:45 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Lester A. Wall Jr				ADDRESS (Street, city or town, state) 1039 St Paul St Baltimore Md			
PHYSICIAN'S NAME (Type) LESTER A. WALL JR				DATE SIGNED 12/28/61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 12/30/61		22c. NAME OF CEMETERY OR CREMATORY Lorraine		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John T. Stansbury ADDRESS 6411 Windsor Mill Rd				24a. REC'D BY REGISTRAR DEC 29 1961		24b. REGISTRAR'S SIGNATURE Quinton S. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1942

10/10/42

MALE

WHITE

BOND

WILLIAM STATE DEPARTMENT OF HEALTH
BALTIMORE, MARYLAND

DATE OF DEATH
PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

UNDERLYING CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

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14



13543

CERTIFICATE OF DEATH

13521

Item 11 Film G305 1/8/63

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb 9yr3 mth10dys		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland		b. COUNTY ✓	
3. NAME OF DECEASED (Type or print) Law rence		First Law		Middle rence		Last DERRY		4. DATE OF DEATH Month December Day 31 Year 1961	
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 3, 1872		9. AGE (In years last day) 89 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) railroad		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County, State, or foreign country) Loudoun, Co., Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Philip Derry	
14. MOTHER'S MAIDEN NAME Mary Attwell		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus 420-1 DUE TO (b) Chronic C.V.D. with myocardial infarct Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____		21. I certify that (I) (this hospital) attended the deceased from September 20, 1952 to December 31, 1961 , that (I) (we) last saw the deceased alive on Dec. 31, 1961 , and that death occurred at 3:05 P.M. from the causes and on the date stated above.	
22a. SIGNATURE Gertrude J. Fleischmann M.D.		22b. DATE SIGNED 12-31-61		22c. PHYSICIAN'S NAME (Type) GERTRUDE J. FLEISCHMANN		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland		22e. DATE SIGNED 12-31-61	
23a. BURIAL, CREMATION, or REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1-4-62		23c. NAME OF CEMETERY OR CREMATORY ST MARYS		23d. LOCATION (City, town or county) (State) HAMPDEN BALTIMORE Md		24. FUNERAL DIRECTOR'S SIGNATURE Frank W. Seitz ADDRESS 814 W 36th St. Balto. 11, Md.	
25a. REC'D BY REGISTRAR DATE JAN 3 '62		25b. REGISTRAR'S SIGNATURE William S. Pinner							

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FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13544 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 3 Film G304 1/3/62 iwk

Reg. Dist. 13522

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY BALTO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE Convent	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RECEDO KNOLL		e. STREET ADDRESS 6011 DAUGHTERS OF THE Eucharist MAIDEN CHOICE LANE	
3. NAME OF DECEASED (Type or print) SISTER M. CECILIA DIETZ		4. DATE OF DEATH Month DEC. Day 21 Year 1961	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 25, 1873
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months 8 Days 8	IF UNDER 24 HRS. Hours 8 Min. 8
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NURSING		10b. KIND OF BUSINESS OR INDUSTRY RELIGIOUS	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME LAWRENCE D. DIETZ		14. MOTHER'S MAIDEN NAME MARY BARLAGE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. —	
17. INFORMANT SISTER CLARA - RECEDO KNOLL		Address RECEDO KNOLL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Cardiac vascular disease (c) — PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. —	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —		20c. TIME OF INJURY Month, Day, Year 19 Hour — a. m. — p. m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	
20f. (City or town) — (County) — (State) —		21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE GEO. S. M. KIEFFER M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED Keen	
EXAMINER'S NAME (Type) GEO. S. M. KIEFFER MD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER 1070 Sedan	
22a. BURIAL, CREMATION, REMOVAL (Specify) ENTOMBMENT		22b. DATE THEREOF 12-23-61	
22c. NAME OF CEMETERY OR CREMATORY CONVENT MAUSOLEUM		22d. LOCATION (City, town, or county) CATONSVILLE (State) MD.	
23. FUNERAL DIRECTOR'S SIGNATURE July - C. ... Catonsville, Md.		24a. REC'D BY REGISTRAR DATE DEC 27 '61	
24b. REGISTRAR'S SIGNATURE C. ... & ...		24c. REGISTRAR'S SIGNATURE —	

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STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13545 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13523

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>NEW YORK</u> b. COUNTY <u>Bronx</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Villa Nova - Balt</u>		c. LENGTH OF STAY IN 1b <u>Dec 26 - '61</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW YORK CO. N. Y.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7309 Prince George Rd.</u>			d. STREET ADDRESS <u>1517 Taylor Ave -</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>John R. Dilworth</u>			4. DATE OF DEATH Month <u>12</u> - Day <u>28</u> Year <u>1961</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-4-1886</u>	9. AGE (in years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Automobile -</u>		11. BIRTHPLACE (State or foreign country) <u>New Yorktown.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>William Dilworth</u>		
14. MOTHER'S MAIDEN NAME <u>Emme Ringland</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes W. W. I.</u>		
16. SOCIAL SECURITY NO. <u>265-50-9334</u>			17. INFORMANT <u>Theresa Dilworth, wife</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Disease -</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>none</u>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.) <u>none</u>		
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>none</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>	
20f. (City or town) <u>none</u>		20g. (County) <u>none</u>		20h. (State) <u>none</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>D. D. Caples</u>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>D. D. CAPLES</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED <u>12-28-61</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/2/62</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>	
22d. LOCATION (City, town, or county) <u>233rd Bronx - N. Y.</u>		22e. (State) <u>N. Y.</u>		22f. (Country) <u>U.S.A.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell, Pikeville 8 Ind</u>			24a. REC'D BY REGISTRAR <u>JAN 2 '62</u>		
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>			24c. (City, town, or county) <u>none</u>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be written in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1935 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT

M

1. Name of Deceased: JOHN J. BROWN

2. Age: 45 Sex: M

3. Date of Death: 10-15-35 Place of Death: Home

4. Cause of Death: Myocardial Infarction

5. Manner of Death: Natural

6. Signature of Medical Examiner: [Signature]

7. Date of Examination: 10-15-35

8. Name of Hospital: St. Joseph's Hospital

9. Name of Physician: Dr. J. H. Smith

10. Name of Coroner: Mr. J. H. Smith

11. Name of Registrar: Mr. J. H. Smith

12. Name of Undertaker: Mr. J. H. Smith

13. Name of Burial Place: St. Joseph's Cemetery

14. Name of Burial Date: 10-18-35

15. Name of Burial Place: St. Joseph's Cemetery

16. Name of Burial Date: 10-18-35

17. Name of Burial Place: St. Joseph's Cemetery

18. Name of Burial Date: 10-18-35

19. Name of Burial Place: St. Joseph's Cemetery

20. Name of Burial Date: 10-18-35

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13524

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN lb MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1627 Jeffers Road		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson d. STREET ADDRESS 6457 Blenheim Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SERINA ALTOMARE		4. DATE OF DEATH Dec. 28, 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 1, 1910
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY USA		13. FATHER'S NAME Liborio Altomare	
14. MOTHER'S MAIDEN NAME Rose Brocato		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. No		17. INFORMANT Nina D. McGarry-1627 Jeffers Rd., Towson	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Chronic Glomerular Nephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 39 yrs. DUE TO (b) 30 yrs. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatic Valvular Heart Disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 30 yrs	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from June 26, 1959 , to Dec 28, 1961 , that (I) (we) last saw the deceased alive on Dec 27, 1961 , and that death occurred at 6:40 A.M. from the causes and on the date stated above.			
22a. SIGNATURE W. M. Conway		22b. DATE SIGNED 12/28/61	
22c. PHYSICIAN'S NAME (Type) W. M. Conway M.D.		22d. ADDRESS 8358 Loch Raven Blvd Towson Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/2/62	23c. NAME OF CEMETERY OR CREMATORY New Cathedral	23d. LOCATION (City, town or county) Baltimore, Maryland (State) _____
24 FUNERAL DIRECTOR'S SIGNATURE Wm Cook-Towson, Inc.		25a. REC'D BY REGISTRAR JAN 2 '62	
ADDRESS 1050 York Rd. Towson Md.		25b. REGISTRAR'S SIGNATURE L. H. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

(A)

Baltimore

Towson

1027 Jellars Road

SERIAL

Female White

Houswife

Liborio Altomare

No

ALTERNATE

X

DINARD

Dec. 1, 1910

Baltimore, Maryland

Rose Prosser

Miss D. Mearns-1027 Jellars Rd., Towson

6427 Elanheim Road

Dec. 28,

51

USA

Towson

Maryland

Baltimore

X

61

Am Cook-Towson, Inc. 1050 York Rd. Towson
New Cathedral
Baltimore, Maryland

1/2/62

Burial

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 13525

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore city	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eudowood - Towson 4, Md.		d. STREET ADDRESS 1840 Pennsylvania Av. -658-W--Saratoga-St.	
3. NAME OF DECEASED (Type or print) First Rodell Middle Denise Last DuBose		4. DATE OF DEATH Month 12 Day 21 Year 19 61	
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-17-58
9. AGE (In years last birthday) 3 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) child		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Raspberry DuBose		14. MOTHER'S MAIDEN NAME Rodell Chisolm	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) XX		16. SOCIAL SECURITY NO. XXX	
17. INFORMANT Personal History Hospital Records, Eudowood Sanatorium		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tuberculous meningitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 010X DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 14 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ---		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-28-61 , xx , to 12-21 , 1961 , that I last saw the deceased alive on 12-21 , 1961 , and that death occurred at 3:10P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Eudowood Sanatorium DATE SIGNED ACTUAL SIGNATURE A. H. Finkelstein, M.D. M.D. PHYSICIAN'S NAME (Type) A. H. Finkelstein, M.D. Towson 4, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-25-61	
22c. NAME OF CEMETERY OR CREMATORY National Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE Adolphus Halstead 918 Druid Hill Ave.		24a. REC'D BY REGISTRAR DATE DEC 27 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 13526

13548

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3618 Langrehr Road		d. STREET ADDRESS 3618 Langrehr Road	
3. NAME OF DECEASED (Type or print) First William Middle Calhoun Last Dunn		4. DATE OF DEATH Month December Day 6 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 8, 1892
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months 68 Days 0 Hours 0 Min.	11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Linotype Operator		10b. KIND OF BUSINESS OR INDUSTRY Sun Paper	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Dunn		14. MOTHER'S MAIDEN NAME Isabelle Calhoun	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W.W.1		16. SOCIAL SECURITY NO. 213-03-3195	
17. INFORMANT Dora Dunn		Address 3618 Langrehr Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 weeks 4 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/10, 1954 to 12/6, 1961 , that I last saw the deceased alive on 12/4, 1961 , and that death occurred at 11:05 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Edwin L. Pierpont		ADDRESS (Street, city or town, state) 8204 LIBERTY RD BALTO, MD	
PHYSICIAN'S NAME (Type) EDWIN L. PIERPONT, MD		DATE SIGNED 12/6/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/9/61	22c. NAME OF CEMETERY OR CREMATORY St. Luke's Cemetery	22d. LOCATION (City, town, or county) (State) Cumberland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost		ADDRESS 4600 Liberty Heights Ave.	
24a. REC'D BY REGISTRAR DEC 11 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

(M)

NAME OF DECEASED
DATE OF DEATH

PLACE OF DEATH
CITY AND COUNTY

DATE OF BIRTH
PLACE OF BIRTH

EDUCATION
OCCUPATION

CAUSE OF DEATH
MANNER OF DEATH

SEX
RACE

RELIGION
MARRIAGE

PREVIOUS ILLNESS
PREVIOUS SURGERY

PREVIOUS TRAUMA
PREVIOUS DRUGS

PREVIOUS ALCOHOL
PREVIOUS TOBACCO

PREVIOUS OTHER
PREVIOUS OTHER

PREVIOUS OTHER
PREVIOUS OTHER

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13549

CERTIFICATE OF DEATH

Reg. Dist. No. 13527

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>3V01-4</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>4yr2mth28dys</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edgar</u> Middle <u>Leo</u> Last <u>Dunnock</u>		4. DATE OF DEATH Month <u>December</u> Day <u>1</u> Year <u>1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 5, 1884</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>claims adjuster</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LAW</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>unknown JOHN DUNNOCK</u>		14. MOTHER'S MAIDEN NAME <u>Alice?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>215-07-8374</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic cardiovascular disease</u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic brain syndrome assoc. with cerebral arteriosclerosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 3, 1957</u> , to <u>Dec. 1, 1961</u> , that I last saw the deceased alive on <u>Dec. 1, 1961</u> , and that death occurred at <u>9:45 P.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland</u> DATE SIGNED <u>12-2-61</u>			
ACTUAL SIGNATURE <u>Jose R. Arizaga, M.D.</u>		PHYSICIAN'S NAME (Type) <u>JOSE R. ARIZAGA</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-5-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Carruthers Funeral Home - Catonsville</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 11 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneiss</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13550						13528					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY BALTIMORE						a. STATE MARYLAND					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore					
c. LENGTH OF STAY IN 1b 86 days						d. STREET ADDRESS 305 S. Chapel Gate Road					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) HARRY C. ECK						4. DATE OF DEATH DECEMBER 2 1961					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 1, 1893		9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cashier				10b. KIND OF BUSINESS OR INDUSTRY RACE TRACK				11. BIRTHPLACE (County & State, or foreign country) Baltimore Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY ECK						14. MOTHER'S MAIDEN NAME MARY I. HALL					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WWI						16. SOCIAL SECURITY NO. 216-05-9317		17. INFORMANT Clinical Records, VA Hospital Baltimore, Md. Ft. Howard Division			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MALIGNANT LYMPHOBLASTOMA											
DUE TO (b)											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
PULMONARY TUBERCULOSIS, MODERATELY ADVANCED INACTIVE											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from September 7, 1961 to December 2, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on December 2, 1961 , and that death occurred at 3:45 PM from the causes and on the date stated above.											
22a. SIGNATURE PAUL G. KOUKOULAS, M.D.						22b. DATE SIGNED 12/2/61					
22c. PHYSICIAN'S NAME (Type) PAUL G. KOUKOULAS, M.D.						22d. ADDRESS VAH, BALTIMORE, MD. - FT HOWARD DIVISION					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 12-6-61		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL				23d. LOCATION (City, town or county) (State) BALTIMORE 28, MARYLAND	
24. FUNERAL DIRECTOR'S SIGNATURE WM Cook-Blight, Inc. 6009 Harford Rd. Balto 11, MD						25a. REC'D BY REGISTRAR DEC 5 '61		25b. REGISTRAR'S SIGNATURE Wm S. Thomas			

13328

13328

(M)

(1)

Wm. Coolidge, Inc. 6002 Broadway St. New York, N.Y.

13-1-1

[Handwritten signature]

WILLIAM COOLIDGE, INC. 6002 BROADWAY ST. NEW YORK, N.Y.

September 7, 1931

October 2, 1931

13328

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13551

Item 23b, Film G304 1/2/62 1wk

13529

1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland				b. COUNTY Caroline							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 50 Days				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Goldsboro,							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital				d. STREET ADDRESS 05X-2				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First ROBERT Middle -- Last EDGE				4. DATE OF DEATH Month DECEMBER Day 22 Year 1961											
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 20, 1895		9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman				10b. KIND OF BUSINESS OR INDUSTRY Automobile Parts				11. BIRTHPLACE (County & State, or foreign country) Henderson, Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Samuel Edge				14. MOTHER'S MAIDEN NAME Della Pritchett											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 216-10-0699				17. INFORMANT VA HOSPITAL, BALTIMORE, MD. FORT HOWARD DIV. CLINICAL RECORDS							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RIGHT CEREBRAL THROMBOSIS DUE TO (b) ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. XXXX (c) XXXX										INTERVAL BETWEEN ONSET AND DEATH 20 DAYS					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CARCINOMA OF RECTUM WITH METASTASIS. 2. ARTERIOSCLEROTIC HEART DISEASE										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) November 2, 1961		(County) DECEMBER 22, 1961		(State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from November 2, 1961 to December 22, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on December 22, 1961 , and that death occurred 8:40 PM from the causes and on the date stated above.															
22a. SIGNATURE Elizah Saunders				M.D. ELIJAH SAUNDERS, M. D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		12/22/61		22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) ELIJAH SAUNDERS, M. D.				22d. ADDRESS VAH, BALTO. MD. FT HOWARD DIVISION											
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 12/27/61		23c. NAME OF CEMETERY OR CREMATORY GREENSBORO, CEMETERY				23d. LOCATION (City, town or county) GREENSBORO, MD.					
24. FUNERAL DIRECTOR'S SIGNATURE J. E. Baeris Greensboro, Md.				ADDRESS		25a. REC'D BY REGISTRAR DATE DEC 27 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Hume							

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MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13552

CERTIFICATE OF DEATH

13530

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown c. LENGTH OF STAY IN 1b Randallstown d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8706 Church Lane		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown d. STREET ADDRESS 8706 Church Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Nathaniel Last Edwards		4. DATE OF DEATH Month December Day 28 Year 1961	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 1, 1884
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months 77 Days 77 Hours 77 Min. 77	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Preacher		10b. KIND OF BUSINESS OR INDUSTRY North Carolina	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Annie Randalls	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Edna B. Edwards 8706 Church Lane	
17. INFORMANT Edna B. Edwards 8706 Church Lane		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) VENTRICULAR FIBRILLATION DUE TO CARDIAC (MYOCARDIAL) FAILURE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. ARTERIOSCLEROTIC C-V DISEASE (b) ARTERIOSCLEROTIC C-V DISEASE (c) ARTERIOSCLEROTIC C-V DISEASE		INTERVAL BETWEEN ONSET AND DEATH 6 hrs. several years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) none		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1961 to Dec. 1961 , that (I) (we) last saw the deceased alive on Aug 28 1961 , and that death occurred at 3:20 PM , from the causes and on the date stated above.			
22a. SIGNATURE Harold H. Weinberg M.D.		22b. DATE SIGNED Dec. 29 '61	
22c. PHYSICIAN'S NAME (Type) HAROLD H. WEINBERG M.D.		22d. ADDRESS 9015 LIBERTY RD, RANDALLSTOWN, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan 1, 1962	
23c. NAME OF CEMETERY OR CREMATORY St. Thomas Cam.		23d. LOCATION (City, town, or county) (State) Randallstown	
24. FUNERAL DIRECTOR'S SIGNATURE William C. March ADDRESS 928 E. North Ave.		25a. REC'D BY REGISTRAR JAN 2 62 DATE	
25b. REGISTRAR'S SIGNATURE William C. March			

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OFFICE OF THE

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13531

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore County, MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore Co.	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN TB 2 days		d. STREET ADDRESS 2806 Silver Hill Road	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Spring Grove State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last LEMUEL R. ELEY		4. DATE OF DEATH Month Day Year December 22, 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-15-24
9. AGE (In years last birthday) 37 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Arkansas		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph B. Eley		14. MOTHER'S MAIDEN NAME Constance Reeves	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 461-44-2838	
17. INFORMANT Mrs. Hazel Eley		Address 2806 Silver Hill Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Patty Liver S81.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) partial			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Howard G. Shaub M.D. EXAMINER'S NAME (Type) HOWARD G. SHAUB, M. D. Address (Street, city, town, or county) 12/23/61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-26-61	22c. NAME OF CEMETERY OR CREMATORY Glen Abbey Memorial	22d. LOCATION (City, town, or country) (State) Lake Wales, Fla.
23. FUNERAL DIRECTOR ADDRESS Ullrich Funeral Home Baltimore, Md.		24a. REC'D BY REGISTRAR DATE DEC 27 '61 24b. REGISTRAR'S SIGNATURE Charles E. Kenna	

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REPORT OF THE

COMMISSIONER OF THE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13554

CERTIFICATE OF DEATH

13532

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN b 3 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 2 d. STREET ADDRESS 1215 North Calvert Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) ROBERT PYNE ELLIOTT			4. DATE OF DEATH December 7 1961		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH October 11, 1890		9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months 7 Days 19 Hours 61 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chef		10b. KIND OF BUSINESS OR INDUSTRY Hotel		11. BIRTHPLACE (Country & State, or foreign country) Long Branch, N. Jersey	
13. FATHER'S NAME William Pyne		14. MOTHER'S MAIDEN NAME Charlotte MN: Unknown		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I 218-01-2242		17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland Fort Howard Division	
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) BRONCHOPNEUMONIA 491X DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease. Senile Emphysema, chronic. Nephritis Manifesting Uremia.				INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) December 4, 1961		(County)		(State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 4, 1961 to December 7, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 12/7/61 19....., and that death occurred at 9:00 P.M. from the causes and on the date stated above.					
22a. SIGNATURE I. F. Freeman		22b. DATE SIGNED 12/8/61		22c. PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D., Medical Service	
22d. ADDRESS VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-12-61		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery	
23d. LOCATION (City, town or county) Baltimore		(State) 28, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Nlight, Inc.		ADDRESS 6009 Harford Rd., Balto 14		25a. REC'D BY REGISTRAR DEC 13 '61	
25b. REGISTRAR'S SIGNATURE Carlton S. Hanna					

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Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore Co.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b appr 1 mth		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Towson Convalescent Home				d. STREET ADDRESS 619 St. Francis Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Katherine		First Katherine		Middle Emory		Last Emory	
4. DATE OF DEATH December 13, 1961		Month December		Day 13		Year 1961	
5. SEX F.		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct 2, 1881	
9. AGE (In years last birthday) 80 yrs.		10. UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Hessen, Germany		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Hessen, Germany		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME Lissie Pfifer		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			
16. SOCIAL SECURITY NO. 214-01-2829		17. INFORMANT Mrs Anton Schwarzkopf		Address 619 St. Francis Rd			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Arteriosclerosis (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 9, 1961, to Dec. 13, 1961, that (I) (we) last saw the deceased alive on Dec. 13, 1961, and that death occurred at 11:30 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Laurence C. Post		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Dr. Laurence C. Post		22d. ADDRESS 6805 York Road, Balto. 12, Md.		22b. DATE SIGNED 12/14/61			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec 18, 1961		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial Park, ElkrIDGE, Maryland		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE John A. Moran		3000 E. Baltimore St.		25a. REC'D BY REGISTRAR DATE DEC 18 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Harris	

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CERTIFICATE OF DEATH

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TO HOSPITAL or ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13556 CERTIFICATE OF DEATH 13534

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> c. LENGTH OF STAY IN 1b <u>34 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2706 Taylor Ave</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X Parkville</u> d. STREET ADDRESS <u>2706 Taylor Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>George McKar (or) M. Evans</u>		4. DATE OF DEATH <u>DEC 13 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Feb 19 - 1908</u>
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Paper Hanger</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Balto. Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>		13. FATHER'S NAME <u>Peter Evans</u>	
14. MOTHER'S MAIDEN NAME <u>Margaret Meis</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>218-18-1779</u>		17. INFORMATION <u>Margaret Evans</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary atherosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>few minutes</u> <u>Sign</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1960</u> to <u>Dec 1961</u> , that (I) (we) last saw the deceased alive on <u>Dec 1961</u> , and that death occurred at <u>1:05 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>William Harris</u>		22b. ADDRESS <u>8100 HARFORD ROAD</u>	
22c. PHYSICIAN'S NAME (Type) <u>S ELLIOTT HARRIS</u>		22d. ADDRESS <u>8100 HARFORD ROAD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 16-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cem</u>		23d. LOCATION (City, town or county) (State) <u>O'Donnell St Balto Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Duppel Bros 7110 Belair Rd</u>		25a. REC'D BY REGISTRAR <u>DEC 18 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles S. Evans</u>		25c. DATE <u>DEC 18 '61</u>	

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Johnville

George McVicker of Evans

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Miss White

Nov 12 - Nov 23

John Hunter

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Pat. F. Jones

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Nov 12 - Nov 23

Nov 12 - Nov 23

James (Bob) and Baker Ltd

James (Bob) and Baker Ltd

James (Bob) and Baker Ltd

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dis. No. 13535

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 17 months 17 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
f. STREET ADDRESS 514 Allendale Street		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Emma S. Fisher		4. DATE OF DEATH Dec. 25, 1961	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 15, 1868
9. AGE (In years last birthday) 93 1/2 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) seamstress		10b. KIND OF BUSINESS OR INDUSTRY own	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Fisher		14. MOTHER'S MAIDEN NAME Wilhemina	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs Virginia McLaughlin, Milbridge		Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY ARTERY DISEASE DUE TO (c) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 14, 1958 , to Dec. 25, 1961 , that I last saw the deceased alive on 12-25-61 , and that death occurred at 9-20 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Alexander		DATE SIGNED 12-25-61	
PHYSICIAN'S NAME (Type) ARISTIDES M. SIMOPOULOS		ADDRESS Spring Grove State Hospital	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/27/61	
22c. NAME OF CEMETERY OR CREMATORY Louisa Park Cmty.		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke, 4101 Edmondson Ave.		24a. REC'D BY REGISTRAR DEC 27 '61	
24b. REGISTRAR'S SIGNATURE William E. Kross			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased John Fisher	
Date of Death May 10, 1940	
Place of Death Baltimore, Maryland	
Age of Deceased 65 years	
Sex Male	
Race White	
Cause of Death Coronary Thrombosis	
Date of Birth May 10, 1875	
Place of Birth Baltimore, Maryland	
Occupation Clerk	
Signature of Physician [Signature]	
Signature of Registrar [Signature]	

CERTIFICATE OF DEATH

Reg. Dist. No. 13536

13558

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OSSEX</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>318 NICHOLSON AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>OTHEL</u> First <u>FISHER</u> Middle <u>JOHN</u> Last		4. DATE OF DEATH <u>DECEMBER 9</u> 19 <u>61</u> Month Day Year	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>27 APRIL 1890</u>
9. AGE (In years lost birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BALTIMORE MD</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>EBBERTS</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH DANIELS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u> INFORMANT <u>ALFRED J. FISHER</u> Address <u>8336 OAKLIEGH RD (14)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>DEHYDRATION</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>METASTATIC CARCINOMA</u> DUE TO <u>CARCINOMA STOMACH</u> (c) <u>6 MONTHS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>11 DAYS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/9</u> , 19 <u>61</u> , to <u>12/9</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>5:30 PM 12/9</u> , 19 <u>61</u> , and that death occurred at <u>6:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George J Burke</u>		ADDRESS (Street, city or town, state) <u>101 W 38th ST</u>	
PHYSICIAN'S NAME (Type) <u>GEORGE J BURKE</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>13 DEC 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Pratt</u> ADDRESS <u>1111 KICKER ST</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 13 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

1955
CERTIFICATE OF DEATH
JAMES EARL RAY
BORN 1928
DIED 1968
Cause of Death: ...
Place of Death: ...
Buried at: ...
Witnessed by: ...
Signed: ...
Date: ...

13559

CERTIFICATE OF DEATH

Reg. Dist. No. 13537

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havans</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto.</u> 03X-1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>423 Schwartz Ave</u>				d. STREET ADDRESS <u>2102 Barclay St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>FLANAGAN</u> Last <u>JR.</u>				4. DATE OF DEATH Month <u>12</u> Day <u>27</u> Year <u>1961</u>			
5. SEX <u>m</u>		6. COLOR OR RACE <u>negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 9. 1903</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired (mail handler)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Post Office</u>		11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>Henry Flanagan Sr</u>				14. MOTHER'S MAIDEN NAME <u>Mary Walker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-03-0633</u>		INFORMANT Address <u>Solomon Mason- 2102 Barclay St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MULTIPLE MYELOMA</u> <u>203X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>60</u> , to <u>Dec 27</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Dec 27</u> , 19 <u>61</u> , and that death occurred at <u>3:30</u> PM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. S. Chalfant</u> M.D.				ADDRESS (Street, city or town, state) <u>6210 York Road</u> DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>Dr. A. S. CHALFANT</u>				<u>Baltimore, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>12/30/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary</u>		22d. LOCATION (City, town, or county) (State) <u>Anne Arundel Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. L. Chaturangh</u>				ADDRESS <u>1701 McCall St. Balto, Md.</u>		24a. REC'D BY REGISTRAR <u>AN 2 '62</u>	
				24b. REGISTRAR'S SIGNATURE <u>Clinton L. Thomas</u>			

CERTIFICATE OF DEATH

1925

1925

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within _____ hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13550 CERTIFICATE OF DEATH 13338											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Masonic Home</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore 29</u> d. STREET ADDRESS <u>116 Westowne Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Zelda I Forrest</u>				4. DATE OF DEATH <u>Dec 21 1961</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 6, 1879</u>		9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Clarke</u>				14. MOTHER'S MAIDEN NAME <u>Irene Gray</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Masonic Home, Cockeysville, Md</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular</u> DUE TO (b) <u>dissection</u> DUE TO (c) <u>dissection</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (<u>this hospital</u>) attended the deceased from <u>Oct 19</u> to <u>Dec 21</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>Dec 21</u> , 19 <u>61</u> , and that death occurred at <u>12:30 P</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Elizabeth B. Sherrill</u>				22b. DATE SIGNED				22c. PHYSICIAN'S NAME (Type) <u>Elizabeth B. Sherrill</u>			
22d. ADDRESS <u>Cockeysville, Md.</u>				22e. REC'D BY REGISTRAR <u>DEC 26 '61</u>				22f. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>12-26-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		23d. LOCATION (City, town or county) <u>Baltimore</u>		23e. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul Street</u>				24b. ADDRESS <u>ZONE 2</u>							

13550

14, 1904

Cooneyville

Reading Room

13550

14, 1904

Cooneyville

Reading Room

none

no

Cooneyville, N.H.

12-26-11

Wm. Cook, Inc., 1117 St. Paul Street, Room 2

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13340

13562

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN MD d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) House in the Pines 16 Fusting Avenue				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 153 S. Collins Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED First William Middle D. Last Gaierty (Type or print)				4. DATE OF DEATH Month December Day 9 Year 1961							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 19, 1881		9. AGE (In years last birthday) 80 yrs. IF UNDER 1 YEAR: Months 80 Days 0 Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bar Tender (Ret'd)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John William Gaierty				14. MOTHER'S MAIDEN NAME Bridgett M. Delaney							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO.		17. INFORMANT John W. Gaierty Address 153 S. Collins Ave.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Hypostatic Pneumonia DUE TO (b) Cerebral and General Arteriosclerosis DUE TO (c) a Cerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH 30 days 2 Months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from 11/15/61 to 12/9/61 , that (I) (we) last saw the deceased alive on 12/17/61 , and that death occurred at 9:00 A.M. from the causes and on the date stated above.											
22a. SIGNATURE Eliot W. Johnson						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/11/61			
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS 3432 Inglewood Ave Baltimore MD 29					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Dec. 13, 1961		23c. NAME OF CEMETERY OR CREMATORY St. Peter's Cemetery		23d. LOCATION (City, town or county) Baltimore, Maryland			
24 FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc.						ADDRESS 1217 St. Paul Street		25a. REC'D BY REGISTRAR DATE DEC 12 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kenna	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 1 of 2 may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13193

Baltimore

Upperville

to the line
of the line

William

also

for the line

John William Galley

to

John W. Galley

William Cook, Inc.

Galley

July 19, 1931

Baltimore, Maryland

Baltimore, Maryland

John W. Galley

John W. Galley

John W. Galley

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

15563

13541

Items 8 & 9 Film Q304 1/2/62 iwk

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville,		c. LENGTH OF STAY IN lb 7 yrs.		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland		b. COUNTY Brooklyn	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Summitt Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4. DATE OF DEATH 22nd Dec. 1961		5. SEX Female		6. COLOR OR RACE White	
3. NAME OF DECEASED (Type or print) George Mewshaw		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 3, 1886		9. AGE (In years last birthday) 75		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary	
11. BIRTHPLACE (County & State, or foreign country) Ap.A. Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George Mewshaw		14. MOTHER'S MAIDEN NAME Lina Burch		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. 217 14 6264		17. INFORMANT Mr. Kenneth Gardner		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 260X DUE TO CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. Hypertensive Cardio-Vascular Disease Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year 17/21/61		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1303 Frederick Rd	
20f. (City or town) Brooklyn		20g. (County) RRF, Maryland		20h. (State) RRF, Maryland		21. I certify that (I) (this hospital) attended the deceased from 17/21/61 to 12/22/61 , that (I) last saw the deceased alive on 17/21/61 , and that death occurred 8:15 PM from the causes and on the date stated above.		22a. SIGNATURE W.E. McGrath MD	
22b. DATE SIGNED 12/23/61		22c. PHYSICIAN'S NAME (Type) W.E. McGrath MD		22d. ADDRESS 1303 Frederick Rd		22e. (State) (28)		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23b. DATE THEREOF 26th Dec. 1961		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town or county) Brooklyn, RRF, Maryland		23e. (State) RRF, Maryland		24. FUNERAL DIRECTOR'S SIGNATURE R.V. Singleton	
24a. REC'D BY REGISTRAR DEC 28 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		24c. ADDRESS Glen Burnie, Md.		24d. (State) Glen Burnie, Md.		24e. (City, town or county) Glen Burnie, Md.	

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Handwritten notes and stamps, including "10000" and "10000".

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13542

13564

Items 11, 12, 13 & 14, Film 9304, 12/20/61

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X CATONSVILLE</u>			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS <u>101 OAKDALE AVE.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>101 OAKDALE AVE.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MAE</u> Middle <u>K.</u> Last <u>CATHWRIGHT</u>				4. DATE OF DEATH Month <u>DEC.</u> Day <u>20</u> Year <u>1961</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/22/76</u>	9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>----- Boyd</u>			
14. MOTHER'S MAIDEN NAME <u>Virginia--- Not Known</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u>			
16. SOCIAL SECURITY NO. <u> </u>				17. INFORMANT <u>Correll Cathwright - 101 Oakdale Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIO SCLEROTIC CARDIO-VASCULAR</u> DUE TO <u>MISSIOE</u> (b) <u>PULMONARY EDEMA</u> DUE TO <u>CEMENT</u> (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>12/1</u> to <u>12/20</u> , 1961, that (I) (we) last saw the deceased alive on <u>12/20</u> , 1961, and that death occurred at <u>8:30</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>John H. Shaw M.D.</u>				22b. DATE SIGNED <u> </u>			
22c. PHYSICIAN'S NAME (Type) <u>John H. Shaw M.D.</u>				22d. ADDRESS <u>5800 EUMENAS AVE. BALD. MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-23-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Bald. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Julius Covany & F.H. - Catonsville, Md.</u>				25a. REC'D BY REGISTRAR <u>DEC 27 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur E. Kline</u>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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1st & 2nd AVE

W. K. G. L.

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F. W.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

1 **MARYLAND STATE DEPARTMENT OF HEALTH**
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13543

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> c. LENGTH OF STAY IN lb <u>170 S. BALHOUN ST</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>3V01-4</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> d. STREET ADDRESS <u>170 S. BALHOUN ST</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>WALTER M. GAVIN</u>		4. DATE OF DEATH <u>DEC 26 1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6 Sept 1882</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BALTO CITY</u>	11. BIRTHPLACE (County & State, or foreign country) <u>BALTO MD</u>
13. FATHER'S NAME <u>John Gavin</u>		14. MOTHER'S MAIDEN NAME <u>MARY ANN CANTON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Clifton A. Gavin</u>		Address <u>579 S. FULTON AVE BALTO MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Influenza</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Virus Entertus e Ixeremi</u> DUE TO (c) <u>same</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral arterio sclerosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/25</u> , 19 <u>61</u> to <u>12/26</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>12/26</u> , 19 <u>61</u> , and that death occurred at <u>5 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Cliff Ratliff, Sr.</u> M.D.		22b. DATE SIGNED <u>12/27/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>CLIFF RATLIFF, SR.</u>		22d. ADDRESS <u>4605 EDWARDS AVE #27</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>24 DEC 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ST PETER'S CEM</u>		23d. LOCATION (City, town or county) (State) <u>BALTO MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Notch Walters</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>	
ADDRESS <u>1414 Sticker St</u>		25b. REGISTRAR'S SIGNATURE <u>DEC 28 '61</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13566

13544

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN lb Summit Nursing Home d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) Md. STATE b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville d. STREET ADDRESS 1422 Langford Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Philip Germack, Sr.		4. DATE OF DEATH Month Day Year Dec. 3/61 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 15/75
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Dispatcher United Railway---Balto.Md.		11. BIRTHPLACE (County & State, or foreign country) USA	9. AGE (In years last birthday) 86 yrs.
13. FATHER'S NAME Germack		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> 16. SOCIAL SECURITY NO. 216 09 4299	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 42010 DUE TO Conditions, if any, which gave rise to immediate cause (b) Pulmonary edema Adrioseptotic heart dis. (a), stating the underlying cause last. DUE TO (c) Diabetes mellitus		17. INFORMANT Unknown Address Mrs. Ruth Newark, 1422 Langford Rd. INTERVAL BETWEEN ONSET AND DEATH 1 year	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 11 p.m. 19 61		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from March 1960 to Dec 3, 1961 , that (I) (the) last saw the deceased alive on Dec 3, 1961 , and that death occurred at 11 PM , from the causes and on the date stated above.			
22a. SIGNATURE Christian S. Mass		22b. DATE SIGNED 12/5/61	
22c. PHYSICIAN'S NAME (Type) Christian S. Mass		22d. ADDRESS Balto. Natl. Pike	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/6/61	
23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION (City, town or county) (State) Baltimore 29 Md	
24. FUNERAL DIRECTOR'S SIGNATURE Witzke F.D.4101 E		25a. REC'D BY REGISTRAR DEC 6 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines			

13566

M

Baltimore

Catonsville

Waring Home

Philip German, Jr.

June 15/75

Male White

United States National Railway - Baltimore, Md.

German

212 09 4203 Mrs. Ruth Hewitt, 1482 Langford St.

Baltimore, Md.

April 25/91

State F.B.I.

Division

1
FOR STATE
HEALTH DEPT.

TO DEPUTY CHIEF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, it should be executed by the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13567 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 14 File G303

12/20/61

13545

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto 8.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 8</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2435 Sylvale Rd.</u>		d. STREET ADDRESS <u>2435 Sylvale Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>FRIEDA</u>		4. DATE OF DEATH <u>Dec 13 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1886</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	9. AGE (In years last birthday) <u>75</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Lith</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Nathan Katz</u>		14. MOTHER'S MAIDEN NAME <u>Gertrude unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-26-9223</u>	
17. INFORMANT <u>Mrs. Gertrude Weinberg--Same</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <u>20 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
2Da. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <u>None</u>		2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>None 19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <u>None</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>D.D. Caples</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>D.D. CAPLES</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) <u>Dec 13 '61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/14/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Progress Sick Benefit</u>		22d. LOCATION (City, town, or country) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS INC</u>		24a. REC'D BY REGISTRAR <u>DEC 18 '61</u>	
ADDRESS <u>6010 Reist Rd.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

MEDICAL CERTIFICATION

2

2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 13546

13568

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mesville</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1308 Kerry Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>FRANCES</u> First <u>G. Glickman</u> Middle <u>G. Glickman</u> Last		4. DATE OF DEATH Month <u>12</u> - Day <u>4</u> - Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>New York, N. Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US & IT</u>	
13. FATHER'S NAME <u>Henry Harris</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Leonard Weiss</u> Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Respiratory failure</u> <u>175.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinomatous</u> DUE TO (c) <u>Carcinoma of ovary</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov 8</u> , 19 <u>61</u> , to <u>Dec 4</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Dec 4</u> , 19 <u>61</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>S. Kaplan</u>		ADDRESS (Street, city or town, state) <u>1632 Reisterstown Rd., P. Kos 8, Md.</u> DATE SIGNED <u>12/4/61</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>12-5-61</u>	<u>Mt Carmel</u>	<u>Balto Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Rivera</u> ADDRESS <u>2100 Euter Rd</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 6 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO BURIAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the burial director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

[Faint, mostly illegible handwritten text and printed form fields are visible across the page. The form includes sections for patient information, cause of death, and medical history.]

[Faint signature and date are visible in the lower right section of the form.]

[Vertical text on the right margin, possibly a file number or date, is mostly illegible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within _____ hours after death. Page _____ may be retained by the hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13569

13547

1. PLACE OF DEATH a. COUNTY Baltimore County Beachwood, Md. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beachwood d. STREET ADDRESS 8240 Beachwood Road.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Anna K. Greif First Middle Last		4. DATE OF DEATH Dec 9, 1961 Month Day Year		5. SEX female	
6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar 11, 1896	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife at home		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (County & State, or foreign country) Baltimore	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George Hemmeter-deceased		14. MOTHER'S MAIDEN NAME Amelia Schuster-deceased	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Joseph B. Greif-husband	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Metastatic Carcinoma DUE TO (b) Carcinoma of Gall Bladder 11 mos. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) 12-9, 1961		20g. (County) 12-9, 1961		20h. (State) 12-9, 1961	
21. I certify that (I) (this hospital) attended the deceased from Feb 12-8-1961 to 12-9, 1961 , that (I) (we) last saw the deceased alive on 12-8-1961 , and that death occurred at 12-9, 1961 , from the causes and on the date stated above.		22a. SIGNATURE B. B. Velez M.D.		22b. DATE SIGNED 12/11/61	
22c. PHYSICIAN'S NAME (Type) B. B. Velez		22d. ADDRESS 701 Eastern Ave (21)		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/13/61		23c. NAME OF CEMETERY OR CREMATORY Sacret Heart Cem.	
23d. LOCATION (City, town or county) German Hill Rd		23e. REC'D BY REGISTRAR DATE DEC 12 '61		23f. REGISTRAR'S SIGNATURE Arthur S. Thomas	
24. FUNERAL DIRECTOR'S SIGNATURE C. E. Schimunek		24b. ADDRESS 3331 Brehms Lane		24c. DATE DEC 12 '61	

C. E. Schimnek 3331 Exness Lane

Baptist 12/15/01

Secret Heart Com.

Lebanon Mill Rd

no no

George Barnett - deceased

housewife at home

female white

Anna M. Grell

X

Mar 11, 1895

05

Dec 9, 1901

8340 Beachwood Road.

Beachwood

Id.

CERTIFICATE OF DEATH

13370

<p>NAME OF DECEASED [Faint handwritten name]</p>		<p>AGE [Faint handwritten age]</p>	
<p>SEX [Faint handwritten sex]</p>		<p>RACE [Faint handwritten race]</p>	
<p>DATE OF DEATH [Faint handwritten date]</p>		<p>TIME OF DEATH [Faint handwritten time]</p>	
<p>PLACE OF DEATH [Faint handwritten place]</p>		<p>Cause of Death [Faint handwritten cause]</p>	
<p>Signature of Physician [Faint handwritten signature]</p>		<p>Signature of Registrar [Faint handwritten signature]</p>	

Items 4 & 21 Film G303 12/19/61 iwb

Arthur S. Krauss

VR A15 (4)
15M 9/60



QUESTION

Item 14 Film G304 1/2/62 iwk

CERTIFICATE OF DEATH

Reg. Dist. No. 18550

1. PLACE OF DEATH a. COUNTY		BALTIMORE		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Baltimore 29		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		4420 Alan Drive		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
3. NAME OF DECEASED (Type or print)		First Middle Last		a. STATE b. COUNTY	
Mary Elizabeth Grill				MARYLAND BALTIMORE	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
F.		W.		8. DATE OF BIRTH	
				SEPT. 30, 1871	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years lost birthday) yrs.	
Housewife		at home		90	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Baltimore Maryland		U.S.A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		4. DATE OF DEATH	
Louis Kossman		unknown		Month Day Year	
December 18, 1961					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		INFORMANT	
NO		214 24 6633		3104 Royston Avenue Balto. 14, MD.	
				Mr. C. Franklin Grill	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Crownary Thrombosis		1 DAY	
4201 DUE TO		Hypertension arteriosclerotic C.V. Disease		15 years	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) DUE TO			
		(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
Hour o. m. p. m.		While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20f. (City or town) (County) (State)	
19					
21. I certify that I attended the deceased from Oct 58 to Dec 18, 1961 that I last saw the deceased alive on Dec 18, 1961, and that death occurred at 11:30 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED	
John F. Coolahan		4201 Wilkins Avenue		12/19/61	
ACTUAL SIGNATURE		M.D.			
PHYSICIAN'S NAME (Type)		John F. Coolahan			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY	
Burial		12/22/61		BALTIMORE CEMETERY	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		22d. LOCATION (City, town, or county) (State)	
HENRY SANDER & SONS INC BALTIMORE MD.				BALTIMORE MARYLAND	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		DATE	
				DEC 21 '61	

VS A15 (4)
15M 9/58

1937

CERTIFICATE OF DEATH

(M)

Blank certificate form with faint lines and text, including fields for name, date, and cause of death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13573

CERTIFICATE OF DEATH

Reg. Dist. No. 13551

1. PLACE OF DEATH a. COUNTY <u>Balto. Co.</u> <u>Towson</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Balto.</u> b. COUNTY <u>-</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>3 mo.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		<u>3V01-4</u>	
3. NAME OF DECEASED (Type or print) <u>Aged Men + Aged Womens Home</u>		d. STREET ADDRESS <u>829 Belgian Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
4. NAME OF DECEASED (Type or print) <u>Helga</u> First <u>Forum</u> Middle <u>Haight</u> Last		5. DATE OF DEATH <u>Dec.</u> Month <u>6</u> Day <u>1961</u> Year	
6. SEX <u>F.</u>		7. COLOR OR RACE <u>W.</u>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <u>57</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NURSE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Yakohama Japan</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Paul Nicholas</u>		14. MOTHER'S MAIDEN NAME <u>William Mabel Seymour</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>136-26-5673</u>	
17. INFORMANT <u>Aged Men & Aged Women's Home, Towson</u>		Address <u>Towson</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>193.0</u> DUE TO <u>Glioblastoma of cerebral hemisphere</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>-</u> DUE TO <u>-</u> (c) <u>-</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>19</u>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June 4</u> , 19 <u>61</u> , to <u>December 6</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Dec 6</u> , 19 <u>61</u> , and that death occurred at <u>6:15 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>4 EAST 33RD ST</u> DATE SIGNED <u>-</u>			
ACTUAL SIGNATURE <u>Moreland Edward Day</u> M.D.			
PHYSICIAN'S NAME (Type) <u>NEWLAND EDWARD DAY</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			
22b. DATE THEREOF <u>12-9-61</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>MORELAND MEMORIAL</u>			
22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>W.M. COOK TOWSON</u> ADDRESS <u>1050 YORK ROAD</u>			
24a. REC'D BY REGISTRAR <u>CLARA S. FRANK</u> DATE <u>DEC 12 '61</u>			
24b. REGISTRAR'S SIGNATURE <u>CLARA S. FRANK</u>			

DEPARTMENT OF THE INTERIOR

1973

10/10/73

Mr. C. J. Johnson

3100 E. 1st Avenue

Denver, Colorado 80218

Dear Mr. Johnson:

I am writing you to let you know that

the Bureau of Land Management has received

your letter of October 1, 1973, regarding

the proposed action on the

application for a

patent for

the land described in the

application. The Bureau is currently

reviewing the application and will

contact you again when a decision

has been reached. Very truly yours,

Director, Bureau of Land Management

Enclosure

Very truly yours,

VS. AISME
SM 9/6D

DATE **DEC 29 '61**

Arthur S. Kraus

M

Edward E. Hobbard 4107 Wilkins Avenue
Baltimore, Maryland

April 12/50 - Baltimore, Maryland

Charles J. Hobbard

April 12/50

April 12/50

April 12/50

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13575 CERTIFICATE OF DEATH 13553											
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 10 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 18 d. STREET ADDRESS 2901 N. Calvert Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) SAMUEL T. HELMS						4. DATE OF DEATH Month December Day 1 Year 19 61					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 13, 1899		9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician				10b. KIND OF BUSINESS OR INDUSTRY Medicine		11. BIRTHPLACE (County & State, or foreign country) Blacksburg, W. Virginia			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Thomas Helms						14. MOTHER'S MAIDEN NAME Kitty Lee Puckett					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WW II 216-05-0183		17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland Fort Howard Division					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO CORONARY THROMBOSIS Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) DIABETES MELLITUS										INTERVAL BETWEEN ONSET AND DEATH RECENT UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore		20g. (County) Baltimore		20h. (State) Maryland	
21. I certify that (I) (this hospital) attended the deceased from November 21, 1961 to December 1, 1961 , that (I) (we) last saw the deceased alive on December 1, 1961 , and that death occurred at 6:45 A.M. from the causes and on the date stated above.											
22a. SIGNATURE John D. Talbert, M.D. 22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M.D. Acting Chief, Medical Service						22b. DATE 12/1/61		22d. ADDRESS Md.		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 12-4-61		23c. NAME OF CEMETERY OR CREMATORY GREENMOUNT CEMETERY		23d. LOCATION (City, town or county) Baltimore		23e. (State) Maryland		23f. REC'D BY REGISTRAR DEC 5 '61	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto. 14						24b. ADDRESS Md.		24c. REGISTRAR'S SIGNATURE Arthur S. Kline		24d. DATE DEC 5 '61	

VR A15 (4)
15M 9/60

13575



TO: Mr. Tolson
FROM: Mr. [illegible]

TO: Mr. [illegible]
FROM: Mr. [illegible]

TO: Mr. [illegible]
FROM: Mr. [illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

I

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13576						13554					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY Baltimore						a. STATE Maryland					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard						b. COUNTY Baltimore					
c. LENGTH OF STAY IN 1b 64 Days						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital						d. STREET ADDRESS 230 North Patterson Park Avenue					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)				First		Middle		Last		4. DATE OF DEATH	
				CASPER		J.		HERGEL		Month Day Year December 17 19 61	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
Male		White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		November 6, 1887		74 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clothing Cutter				10b. KIND OF BUSINESS OR INDUSTRY Clothing Manufacturing Co. Baltimore, Maryland				11. BIRTHPLACE (County & State, or foreign country) U. S. A.			
12. CITIZEN OF WHAT COUNTRY U. S. A.				13. FATHER'S NAME John Hergel				14. MOTHER'S MAIDEN NAME Josephine Herr			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WW I 215-05-6928				17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH 1 Week			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) STAPHYLOCOCCAL PNEUMONIA, LEFT				DUE TO (b)							
491X				DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (X) (this hospital) attended the deceased from October 14 19 61 to December 17 19 61 , that (X) (we) last saw the deceased alive on December 17 19 61 , and that death occurred at 9:15 A.M. from the causes and on the date stated above.											
22a. SIGNATURE Sebastian Russo						22b. DATE SIGNED 12/18/61					
22c. PHYSICIAN'S NAME (Type) SEBASTIAN RUSSO, M.D.						22d. ADDRESS VAH, BALTIMORE 18, MD., FORT HOWARD DIVISION					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 12-20-61		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery Baltimore Maryland				23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto. 14 Md.						25a. REC'D BY REGISTRAR DEC 20 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Thoma			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

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MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13577

CERTIFICATE OF DEATH

13555

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 16 mos	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Cecilia ^{First} Helen ^{Middle} Holmes ^{Last}		4. DATE OF DEATH Month December Day 1 Year 61	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-7-91
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 10 Days 10 Hours 10 Min. 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William BREWER		14. MOTHER'S MAIDEN NAME Charlotte GILLEN FENNY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic cardiovascular disease DUE TO (c) chronic brain syndrome assoc. with cerebral arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) chronic brain syndrome assoc. with cerebral arteriosclerosis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug. 12 19 60 , to December 1 19 61 , that (I) (we) last saw the deceased alive on Dec. 1 19 61 , and that death occurred at 7:45 PM , from the causes and on the date stated above.			
22a. SIGNATURE Jose R. Arizaga, M.D.		22b. DATE SIGNED 12-2-61	
22c. PHYSICIAN'S NAME (Type) JOSE R. ARIZAGA		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5 DEC 1961	
23c. NAME OF CEMETERY OR CREMATORY NEW CATHOLIC		23d. LOCATION (City, town, or county) (State) BALTO MD	
24. FUNERAL DIRECTOR'S SIGNATURE Not a funeral director		25a. REC'D BY REGISTRAR DATE DEC 4 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. [unclear]			

STATE OF NEW YORK

1937



TO HOSPITAL: The law requires that the death certificate be executed within 48 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13578

Items 13 & 14 Film 9305 1/8/62 mh

13556

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>6132 Marglenn Ave.</u>		d. STREET ADDRESS <u>6132 Marglenn Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Hughes, Sr.</u> Last <u>Hughes</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>29</u> Year <u>1961</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-25-1880</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Bricklayer</u>		11b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Hughes</u>		14. MOTHER'S MAIDEN NAME <u>Mary Anne Ludwick</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Edward Hughes, Jr.</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>422.1</u> IMMEDIATE CAUSE (a) <u>Arterio sclerotic Cardiovascular Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u> yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anemia & Scurvy Prostatitis.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>10:59</u> , 19 <u> </u> , to <u>28 Dec</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>27 Dec</u> , 19 <u>61</u> , and that death occurred at <u>12 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>John C. Hyle</u>		22b. DATE SIGNED <u> </u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN C. Hyle</u>		22d. ADDRESS <u>7527 Belair Rd Balto Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>1-1-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 2 '62</u>	
ADDRESS <u>5305 Harford Road</u>		25b. REGISTRAR'S SIGNATURE <u>Winifred L. Harris</u>	

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13579 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13557

1. PLACE OF DEATH a. COUNTY Baltimore County, MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore County	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TEXAS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Texas	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Railroad Avenue, Texas, Md.		d. STREET ADDRESS Railroad Avenue	
3. NAME OF DECEASED (Type or print) BABY BOY HUSEN		4. DATE OF DEATH Month Day Year December 20, 1961	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 16, 1941
9. AGE (In years last birthday) 19		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Md. (Baltimore City)		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME Howard Clorsey Sr.		14. MOTHER'S MAIDEN NAME Karolthy Huseen	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Howard Clorsey Jr. Sparks, Md.		17. ADDRESS	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Interstitial Pneumonitis 763.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Howard G. Shaub EXAMINER'S NAME (Type) HOWARD G. SHAUB, M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/21/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/23/61	
22c. NAME OF CEMETERY OR CREMATORY Stephenson		22d. LOCATION (City, town, or country) Sparks, Md.	
23. FUNERAL DIRECTOR Am. P. Lotatunaf - 1701 N. Calhoun St. Balto. Md.		24a. REC'D BY REGISTRAR DEC 26 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13580

13558

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 25yr9mth8days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3v01-4	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 1211 North Montford	
3. NAME OF DECEASED (Type or print) First Herbert Middle Hyman Last Hyman		4. DATE OF DEATH Month December Day 17 Year 1961	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 21, 1901
9. AGE (In years lost birthday) yrs. 60		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10b. KIND OF BUSINESS OR INDUSTRY NONE	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles Hyman		14. MOTHER'S MAIDEN NAME Mary Appalonie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive and decompensatory heart failure 410X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Rheumatic valvulitis with deformity of the mitral valve DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 9, 1936 to Dec. 17, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Dec. 17, 1961 , and that death occurred at p. M. from the causes and on the date stated above.			
22a. SIGNATURE Stella Wachsler		22b. DATE SIGNED 12-18-61	
22c. PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/20/61	
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem		23d. LOCATION (City, town, or county) (State) Frederick Rd.	
24. FUNERAL DIRECTOR'S SIGNATURE C. E. Schimunek		25a. REC'D BY REGISTRAR DATE DEC 19 '61	
ADDRESS 3331 Brehms Lane		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

11-23-50

CERTIFICATE OF DEATH

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(M)

11-23-50

11-23-50

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11-23-50

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 13559

13581

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sparks</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sparks</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Yeoho Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Katherine</i> Middle <i>Bauers</i> Last <i>Jefferson</i>		4. DATE OF DEATH Month <i>December</i> Day <i>27</i> Year <i>1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6 December 1879</i>
9. AGE (In years last birthday) <i>82</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>	
11. BIRTHPLACE (State or foreign country) <i>Baroniquien Germany</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Joseph Bauers</i>		14. MOTHER'S MAIDEN NAME <i>Maria ?</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>16</i>	
17. INFORMANT <i>Daughter in law -</i>		Address <i>Same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac decompensation</i> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arterio sclerotic Cardiovascular disease</i> DUE TO (c) <i>15 years</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>1957</i> , to <i>December 1961</i> , that I last saw the deceased alive on <i>19 Dec</i> , 19 <i>61</i> , and that death occurred at <i>8:39</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Walter T. Kees</i> M.D.		ADDRESS (Street, city or town, state) <i>Cockey'sville Maryland</i>	
PHYSICIAN'S NAME (Type) <i>WALTER T. KEES</i>		DATE SIGNED <i>27 Dec 1961</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12-30-61</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Woodlawn Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Balto Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm J. Tucker & Son Balto. Md</i>		24a. REC'D BY REGISTRAR DATE <i>DEC 28 '61</i>	
		24b. REGISTRAR'S SIGNATURE <i>Wm J. Tucker</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 4 and 5 are to be retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MAYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13582
Item 14 Film G302 12/22/61
13560
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u> c. LENGTH OF STAY IN 1b <u>340 10mo.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>College Manor</u>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegheny</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u> <u>01X-2</u> d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>James Jenkins</u> First Middle Last		4. DATE OF DEATH Month <u>12</u> Day <u>15</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 7, 1883</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>8</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Frostburg, Md</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Philip Jenkins</u>	
14. MOTHER'S MAIDEN NAME <u>Ann Thomas</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war and dates of service)	
16. SOCIAL SECURITY NO. <u>213-10-4982</u>		17. INFORMANT <u>M. Heaps, RN</u> Address <u>College Manor</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> <u>Arterio-sclerosis; hemiplegia; 2; hemiplegia 1 wk.</u> DUE TO <u>2</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>May 4, 1957</u> to <u>Dec 15, 1961</u> ; that (I) (we) last saw the deceased alive on <u>Dec 11, 1961</u> , and that death occurred at <u>8:41 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Nathan R. Steiman</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>12/15/61</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>1041 St. Paul St.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12-18-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Frostburg Memorial Park</u>	23d. LOCATION (City, town or county) (State) <u>Frostburg, Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Durst Funeral Home - Frostburg, Md.</u>		25a. REC'D BY REGISTRAR <u>DEC 18 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

525

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13583

Reg. Dist. No. 13561

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN lb 2 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital				d. STREET ADDRESS 1437 Mt. Royal Ave., Baltimore 17		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jane Middle Carlisle Last Jenkins				4. DATE OF DEATH Month December Day 16 Year 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 4, 1916	9. AGE (In years last birthday) 45 yrs.	IF UNDER 1 YEAR Months 45 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Conn.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Louis Pitkin				14. MOTHER'S MAIDEN NAME Laura Carlisle			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unk		17. INFORMANT Address Medical Records—Spring Grove State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 921.7 Congestive heart failure DUE TO Congestive heart failure due to Conditions, if any, which gave rise to immediate cause (b) Tracheobronchial obstruction (c) Tracheobronchial obstruction DUE TO Tracheobronchial obstruction PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenia, chronic undifferentiated							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) While eating coffee and doughnuts, choked					
20c. TIME OF INJURY Month, Day, Year 8:10 P. m. Dec. 16 19 61		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) hospital		20f. (City or town) (County) (State) Catonsville, Balto. Co. Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Geo. S. M. Kieffer M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Geo. S. M. Kieffer M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 1010 Leeds Ave. Dec. 17, 1961			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-20-61		22c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		22d. LOCATION (City, town, or county) (State) Frederick, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. P. Etchison & Son, Frederick, Maryland				24a. REC'D BY REGISTRAR DEC 20 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kras	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
PLACE OF DEATH		CITY		COUNTY		STATE		ZIP CODE	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		MILITARY SERVICE	
PREVIOUS ILLNESS		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL HISTORY		HISTORICAL DATA	
FAMILY HISTORY		SOCIAL HISTORY		PHYSICAL EXAMINATION		LABORATORY TESTS		PATHOLOGICAL FINDINGS	
TREATMENT		HOSPITALIZATION		SURGERY		MEDICATIONS		OTHER THERAPIES	
FOLLOW-UP		PROGNOSIS		REMARKS		SIGNATURE OF EXAMINER		DATE OF SIGNATURE	
FAMILY SIGNATURE		WITNESS SIGNATURE		NOTARY SIGNATURE		NOTARY SEAL		NOTARY COMMISSION EXPIRATION DATE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician. Page 2 should be retained by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

13585

13563

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
c. LENGTH OF STAY IN-IB Life.		d. STREET ADDRESS 222 Westshire Rd.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 222 Westshire Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Henry A. Jockel		4. DATE OF DEATH Dec. 25, 1961	
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 5, 1894
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk, Calvert Drug Co.		10b. KIND OF BUSINESS OR INDUSTRY Md.	
11. BIRTHPLACE (County & State, or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME -----Jockel		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, none, unknown) Yes WW 1		16. SOCIAL SECURITY NO. 212-03-7062	
17. INFORMANT Mrs John Williams, 306 Westown Rd. 28, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO ASCVD - Coronary Artery Disease Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Libman DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Diabetes Mellitus - Peripheral Neuropathy		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1959 to 12/25/61 1961, that (I) (the) last saw the deceased alive on 3/31 1961, and that death occurred at 3:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE James J. Nolan		22b. DATE SIGNED 12/26/61	
22c. PHYSICIAN'S NAME (Type) J. J. NOLAN M.D.		22d. ADDRESS 13000 Hilo Ave Baltimore 29 Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/26/61	
23c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemty.		23d. LOCATION (City, town or county) Randallstown Md. (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Witzke, 4101 Edmondson Ave.		25a. REC'D BY REGISTRAR DEC 29 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas			



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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1
FOR STATE
HEALTH DEPT.

13586

13564

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN b 25 Minutes d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ferndale d. STREET ADDRESS 3 - 5th Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last PAUL M. JOHANCEN				4. DATE OF DEATH Month Day Year December 14 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 2, 1899	
9. AGE (In years last birthday) 62		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Baltimore (Arlington) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor-Ord. Dept. U.S. Navy Yard				10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy Yard			
13. FATHER'S NAME Samuel E. Johancen				14. MOTHER'S MAIDEN NAME Anna Gentner			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW I				16. SOCIAL SECURITY NO. 207-09-1073			
17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland Fort Howard Division				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction, Left Anterior DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Coronary Artery (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). None							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) None			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 12/15/61 ACTUAL SIGNATURE M B Davis M.D. EXAMINER'S NAME (Type) M. B. DAVIS, M.D. Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/18/61		22c. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Park		22d. LOCATION (City, town, or country) (State) Glen Burnie, Maryland	
23. FUNERAL DIRECTOR Hopping and Kirkley ADDRESS 421 Crain Highway, Hopping and Kirkley Funeral Home, Glen Burnie, Md.				24a. REC'D BY REGISTRAR DEC 20 '61 24b. REGISTRAR'S SIGNATURE C. S. Kline			

TO: DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Delay is necessary. Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL
Page 4
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

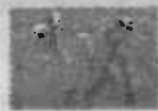
THE LAW REQUIRES THAT THE DEATH CERTIFICATE BE EXECUTED WITHIN 72 HOURS AFTER DEATH.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
13587														
13565														
1. PLACE OF DEATH a. COUNTY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
13. NAME OF DECEASED (Type or print) First Middle Last LEROY ----- JOHNSON					4. DATE OF DEATH Month Day Year December 11 1961									
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 2, 1904		9. AGE (In years last birthday) 57 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stationary Engineer		10b. KIND OF BUSINESS OR INDUSTRY State Building		11. BIRTHPLACE (County & State, or foreign country) Chesterfield Co., Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.								
13. FATHER'S NAME Warner Johnson					14. MOTHER'S MAIDEN NAME Emma Prices									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II					16. SOCIAL SECURITY NO. 217-26-1659					17. ADDRESS Clinical Records, VAH, Baltimore 18, Maryland Fort Howard Division				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOGENIC CARCINOMA LEFT LUNG WITH METASTASES 162-1 XXXX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) RIGHT LOBAR PNEUMONIA DUE TO (a) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH UNKNOWN 3 Days ±						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore		(County) Baltimore		(State) Maryland		
21. I certify that (X) (this hospital) attended the deceased from November 24, 1961 to December 11, 1961, that (X) (we) last saw the deceased alive on 12/11/61, 1961, and that death occurred at 5:15 P.M. from the causes and on the date stated above.										22a. SIGNATURE SEBASTIAN RUSSO, M.D.		22b. DATE SIGNED 12/11/61		
22c. PHYSICIAN'S ADDRESS VAH, BALTIMORE 18, MARYLAND, FT. HOWARD DIV.					22d. ADDRESS VAH, BALTIMORE 18, MARYLAND, FT. HOWARD DIV.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/14/61		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		23d. LOCATION (City, town or county) Baltimore		(State) Maryland						
24. FUNERAL DIRECTOR'S SIGNATURE Elroy O. Wilson, 1000 Brantley Ave., Balto. 17, Md.					25a. REC'D BY REGISTRAR DEC 13 '61					25b. REGISTRAR'S SIGNATURE Arthur S. Kraus				



1958

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TO: Mr. J. Edgar Hoover, Director, Federal Bureau of Investigation, Washington, D.C.
FROM: Mr. [Name], [Address]
SUBJECT: [Subject]
[The following text is mirrored and largely illegible due to bleed-through from the reverse side of the page.]

10/1/58
[Signature]
[Name]
[Address]
[City, State, Zip]

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 4 and 5 are retained by the hospital or attending physician.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL (Specify)

24 FUNERAL DIRECTOR'S SIGNATURE

25a. REC'D BY REGISTRAR

25b. REGISTRAR'S SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13588 CERTIFICATE OF DEATH 13566

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN lb 16 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 2905 Thorndale Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LORENZO H. JOHNSON		4. DATE OF DEATH Month Day Year December 27 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 30, 1889
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Artist		10b. KIND OF BUSINESS OR INDUSTRY Commercial	
11. BIRTHPLACE (County & State, or foreign country) Baltimore Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James T. Johnson		14. MOTHER'S MAIDEN NAME Mary Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 213-30-9612	
17. INFORMANT Clinical Records, VAH, Baltimore, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA DUE TO (b) CHRONIC NEPHRITIS Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that 17 (this hospital) attended the deceased from Dec. 11, 1961 , to Dec. 27, 1961 , that 17 (we) last saw the deceased alive on Dec. 27, 1961 , and that death occurred at 10:15 a.m. on the causes and on the date stated above.			
22a. SIGNATURE Irving Freeman		22b. DATE SIGNED 12/27/61	
22c. PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D.		22d. ADDRESS VAH, BALTIMORE, MD. FT HOWARD DIV.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/30/61	
23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City, town or county) (State) Woodlawn, Md.	
24 FUNERAL DIRECTOR'S SIGNATURE Armacost Funeral Home		25a. REC'D BY REGISTRAR DEC 29 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		25c. ADDRESS Baltimore, Maryland	

VR A15 (4)
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INSTRUCTIONS

TO A **ENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The below copy may be retained by the hospital or attending physician.

TO **FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

13589

CERTIFICATE OF DEATH

13567

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>S.C.</u>		COUNTY <u>Chester</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Quindall</u>		<u>3 yrs</u>		TOWN <u>77X-3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>105 Fairbanks Ct</u>				STREET ADDRESS (If rural give location) <u>Route 4 Box 8</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Joe</u> (Middle) <u>(Joseph)</u> (Last) <u>Jones</u>				(Month) <u>December</u> (Day) <u>23</u> (Year) <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>MARCH 4, 1876</u>	9. AGE last birthday <u>85</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>		11. BIRTHPLACE (State or foreign country) <u>Windsor, S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Joe Jones</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Jackson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Robt B. Erwin 105 Fairbanks</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Artemia</u>						<u>2 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u>						<u>10 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Cerebral Infarct</u>						<u>2 mos</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/> P. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 30, 1959</u> to <u>Dec 23, 1961</u> , that I last saw the deceased alive on <u>Dec 23, 1961</u> , and that death occurred at <u>4:15</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>William C. Goble</u>		ADDRESS (Street, city, town, state) <u>140 Oak Ave, Dundalk, Md</u>		DATE SIGNED <u>12/23/61</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>12/28/61</u>		NAME OF CEMETERY OR CREMATORY <u>Sweet Prospect Cemetery</u>		LOCATION (City, town, or county) (State) <u>Chester, S.C.</u>	
24. REC'D BY REGISTRAR <u>DEC 28 61</u>		REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Robert F. Jones</u>		ADDRESS <u>1129 N. Caroline St. Baltimore 13, Maryland</u>	

CERTIFICATE OF DEATH

DATE 11/22/58

11/22/58

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Baltimore, Md

108 Fairport Rd
Baltimore, Md

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Baltimore, Md

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13590

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dis. 13568

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROSEDALE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROSEDALE (RURAL) BALTIMORE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1436 Rustic Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mildred G Jones		4. DATE OF DEATH Month Dec Day 5 Year 1961	
5. SEX female	6. COLOR OR RACE negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 Sept 1911
9. AGE (In years last birthday) 50 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife - Domestic Church		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME Rebecca Cook	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT John Jones		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardio Vascular Disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis and hypertension DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH undet			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John C. Hyle		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) John C Hyle		DATE SIGNED 12-5-61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-11-61	22c. NAME OF CEMETERY OR CREMATORY Baltimore National	22d. LOCATION (City, town, or county) (State) Baltimore Md
23. FUNERAL DIRECTOR'S SIGNATURE Elroy O. Wilson - 1080 Stanton Ave		24a. REC'D BY REGISTRAR DATE DEC 13 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be written in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1928

Form with multiple sections for medical examination and death certification, including checkboxes and lines for text entry. The form is oriented horizontally but contains vertical text labels for various fields.

Sections include:

- IDENTIFICATION (Name, Address, Age, Sex, Race, Religion, etc.)
- CAUSE OF DEATH (Immediate, Intermediate, Remote)
- DETAILS OF DEATH (Place, Time, Date, etc.)
- POST-MORTEM EXAMINATION (Findings, etc.)
- SIGNATURES (Physician, Medical Examiner, etc.)

Checkboxes are present for various conditions and findings, such as "Heart Disease", "Lung Disease", "Kidney Disease", etc.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13591

13569

13591

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 1mth2ldys	
d. NAME OF HOSPITAL (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle H. Last Jones		4. DATE OF DEATH Month December Day 12 Year 19 61	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Feb. 13, 1891
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) contractor		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Jones		14. MOTHER'S MAIDEN NAME Ann Margaret Taylor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. 218-03-8635	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Oct. 20 19 61 to Dec. 12 19 61 that (I) (we) last saw the deceased alive on Dec. 12 1961 , and that death occurred at 9:00 M, from the causes and on the date stated above.			
22a. SIGNATURE Stella Wachslar		22b. DATE SIGNED 12-12-61	
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/15/61	
23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost		25a. REC'D BY REGISTRAR DEC 13 '61	
ADDRESS -4600 Liberty Hghts. Ave.		25b. REGISTRAR'S SIGNATURE William A. Thomas	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13592

13570

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 2 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore 18 c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 2711 The Alameda d. STREET ADDRESS 3401-4 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) RAYMOND E. KEARNEY		4. DATE OF DEATH Month Day Year December 18 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH October 5, 1898
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months Days 63	11. IF UNDER 24 HRS. Hours Min. 63
12a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Field Office Superintendent		12b. KIND OF BUSINESS OR INDUSTRY Construction	
13. FATHER'S NAME James Francis Kearney		14. MOTHER'S MAIDEN NAME Marcella A. Cain	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 217-05-0146	
17. INFORMANT Clinical Records, VAH, FORT HOWARD DIVISION		18. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland	
19. CITIZEN OF WHAT COUNTRY? U. S. A.		20. INTERVAL BETWEEN ONSET AND DEATH 2 Weeks+	
21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 420-0 CONGESTIVE HEART FAILURE ARTERIOSCLEROTIC HEART DISEASE 7 Years		22. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1. Chronic obstructive Emphysema	
23a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		23b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
24c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		24d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
25c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		26. (City or town) (County) (State) Baltimore	
27. I certify that (this hospital) attended the deceased from Dec. 16 to Dec. 18 , 1961, that (s) (we) last saw the deceased alive on Dec. 18 , 1961, and that death occurred at 3:30 P.M. , from the causes and on the date stated above.		28. SIGNATURE JOHN D. TALBERT, Acting Chief, Medical Service, VAH, Baltimore 18, Md., Ft. Howard Division	
29a. PHYSICIAN'S NAME (Type) JOHN D. TALBERT		29b. DATE SIGNED 12/18/61	
30a. BURIAL, CREMATION, REMOVAL (Specify) Burial		30b. DATE THEREOF 12/21/61	
31. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		32. LOCATION (City, town or county) (State) Baltimore Maryland	
33. FUNERAL HOME SIGNATURE Henry Sander & Sons, Inc., North & Broadway Ave. Baltimore, Md.		34. REC'D BY REGISTRAR DEC 21 '61	
35. REGISTRAR'S SIGNATURE Charles S. Kline		36. DATE 12/18/61	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13593

CERTIFICATE OF DEATH

Reg. Dist. No. 13571

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b 6 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1808 Homberg Avenue				d. STREET ADDRESS 1808 Homberg Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EVA		First Middle Last KELLEY		4. DATE OF DEATH Month Day Year December 12 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 11, 1892		9. AGE (In years lost birthday) 69 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Conrad Kraus				14. MOTHER'S MAIDEN NAME Barbara Kupfrian			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Helen Campbell 1808 Homberg Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Myocarditis with Failure DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 5 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 1955 to Dec 12 61, that I last saw the deceased alive on Dec 10, 1961, and that death occurred at 10:15 AM from the causes and on the date stated above.							
ACTUAL SIGNATURE W. H. Morrison				ADDRESS (Street, city or town, state) 3 Kingship, Dundalk		DATE SIGNED 13 Dec 61	
PHYSICIAN'S NAME (Type) W. H. Morrison							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-15-1961		22c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Jesus		22d. LOCATION (City, town, or county) (State) German Hill Rd. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE JOHN J. DUDA 7922 Wise Ave. 22, Md.				24a. REC'D BY REGISTRAR DATE DEC 14 '61		24b. REGISTRAR'S SIGNATURE C. S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

CORONER: After this certificate has been signed by the attending physician and completed in by the funeral director, it should be filed in the coroner's office.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13594

13572

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>				c. LENGTH OF STAY IN 1b <i>X</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1 Terrace Dale</i>				d. STREET ADDRESS <i>1 Terrace Dale</i>			
3. NAME OF DECEASED (Type or print) First <i>Elizabeth</i> Middle <i>Jenny</i> Last <i>Kenney</i>				4. DATE OF DEATH Month <i>December</i> Day <i>26</i> Year <i>1961</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5 July 1885</i>	9. AGE (In years lost birthday) <i>76</i> yrs.	IF UNDER 1 YEAR Months <i>76</i> Days <i>76</i> Hours <i>76</i> Min.	IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (State or foreign country) <i>Lutherville Balto Co</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Charles Edward Thomas</i>				14. MOTHER'S MAIDEN NAME <i>Carrie Stieber</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Son - Ed Kenney</i> Address <i>Phoenix, Maryland</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331 X</i> DUE TO <i>Cerebral Vascular accident</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <i>Cerebral and Generalized Arteriosclerosis with</i> (c) <i>Hypertension -</i></p> </div> <div style="width: 50%;"> <p>INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i> <i>30 years</i></p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <i>19 25 Dec 61</i> to <i>Dec 61</i> , that (I) (we) last saw the deceased alive on <i>29 Nov 61</i> (19 <i>61</i>) and that death occurred at <i>2 A</i> M, from the causes and on the date stated above.							
22a. SIGNATURE <i>Walter T. Kees</i>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS.	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>26 Dec 1961</i>		
22c. PHYSICIAN'S NAME (Type) <i>Walter T. KEES</i>		22d. ADDRESS <i>Cockeysville Maryland</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE THEREOF <i>Dec. 28, 1961</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Prospect Hill Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Towson, Md.</i>			
24. FUNERAL DIRECTOR'S SIGNATURE <i>John Burns Sons, Towson, Md.</i>			25a. REC'D BY REGISTRAR DATE <i>DEC 29 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Harris</i>		

MEDICAL CERTIFICATION

page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 only should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF TEXAS
COUNTY OF DALLAS
CITY OF DALLAS
DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

1900

1900

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

SIGNATURE OF DECEASED

SIGNATURE OF WITNESS

SIGNATURE OF PHYSICIAN

SIGNATURE OF CLERK

SIGNATURE OF JUDGE

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13595

13573

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			
c. LENGTH OF STAY IN 1b ?				d. STREET ADDRESS 409 Carolina Road			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 409 Carolina Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Dr. Ralph Emerson Kessler				4. DATE OF DEATH Month Day Year 12 8 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-7-1913	
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Director of Spec. Ed Public Schools				10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John E. Kessler				14. MOTHER'S MAIDEN NAME Agnes Pettigrew			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W.W. II				16. SOCIAL SECURITY NO. 200-14-1465		17. INFORMANT Address Mrs. Doris K. Kessler Above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CORONARY OCCLUSION DUE TO (c) CORONARY HEART DISEASE							INTERVAL BETWEEN ONSET AND DEATH 1 HOUR 1 HOUR 1 YEAR
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 2/25 19 54 to 12/8 19 61 , that (I) (we) last saw the deceased alive on 12/7 19 61 , and that death occurred at 6:30 AM from the causes and on the date stated above.							
22a. SIGNATURE Donald L. Somerville				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/8/61	
22c. PHYSICIAN'S NAME (Type) Dr. Donald L. Somerville				22d. ADDRESS 25 W. Pa. Ave. Towson 4, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 12-11-1961		23c. NAME OF CEMETERY OR CREMATORY Green Mount		23d. LOCATION (City, town, or county) (State) Balto. City, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service Towson 4, Md.				25a. REC'D BY REGISTRAR DATE DEC 11 '61		25b. REGISTRAR'S SIGNATURE Arthur E. Thomas	

TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours after death. The funeral director, after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13585

CENTRAL AIR OF DEATH

Belmont

Verdict

Belmont

Town

Town

400 Carolina Road

400 Carolina Road

Dr. Ralph

Dr. Ralph

also

also

Director of Assoc. Ed. Public Schools Pennsylvania

John E. Keener

John E. Keener

Yes

Yes

Public Health Service Town 4, No.

Operation 15-1-1951 - Green Town

Dr. Donald J. J. J.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13596 CERTIFICATE OF DEATH 13574											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1508 Edmondson Ave</u>						d. STREET ADDRESS <u>1508 Edmondson Ave</u>					
3. NAME OF DECEASED (Type or print) <u>FLORENCE KIRKCONNELL</u>						4. DATE OF DEATH Month <u>12</u> Day <u>28</u> Year <u>1961</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/16/90</u>		9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Hom.</u>				11. BIRTHPLACE (County & State, or foreign country) <u>TAM. B.W.I.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edwin Kirkconnell</u>						14. MOTHER'S MAIDEN NAME <u>Catherine Crooks</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16. SOCIAL SECURITY NO. <u>214 40 1163</u>		17. INFORMANT Address <u>Barbara E. Groot</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Concussion of Thoracic Spine metastatic</u> <u>164X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Mediastinal Concussion possibly original</u> DUE TO (c) <u>embolism</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pain Plegia secondary to Spine Concussion</u> INTERVAL BETWEEN ONSET AND DEATH <u>approx 6 hours</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3/23</u> , 19 <u>57</u> , to <u>12/28</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>12/27</u> , 19 <u>61</u> , and that death occurred at <u>12:25</u> AM, from the causes and on the date stated above.											
22a. SIGNATURE <u>Cliff Ratliff Jr.</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12/19/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>CLIFF RATLIFF JR.</u>						22d. ADDRESS <u>4605 EDMONDSON AVE.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>12/31/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Johns</u>		23d. LOCATION (City, town or county) (State) <u>Howard Co. Md.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Donald Ratt + Son (2P)</u>						25a. REC'D BY REGISTRAR DATE <u>JAN 2 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

13214

13214

(M)

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "C. ...", "1902", and "1901" are faintly visible.]

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13597 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13575

1. PLACE OF DEATH a. COUNTY <u>Baltimore Co.</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS <u>4241 Klein Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Louis</u> Middle <u>Klein</u> Last <u>Klein</u>			4. DATE OF DEATH Month <u>12</u> Day <u>28</u> Year <u>1961</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-16-1881</u>		9. AGE (In years last birthday) <u>80</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machine opr</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore Co., Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Charles Klein</u>			14. MOTHER'S MAIDEN NAME <u>Elizabeth Hoffstetter</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>2120-9389</u>		17. INFORMANT <u>Mrs. Frieda Klein</u> Address <u>4241 Klein Ave (6)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420x1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic Cardiovascular Dis.</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>unkn.</u> <u>unde.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined monner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>John E. Hyle</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>12-28-61</u>	
EXAMINER'S NAME (Type) <u>JOHN E. HYLE</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-30-1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassala Funeral Home 7401 Balair Road</u>			
24a. REC'D BY REGISTRAR DATE <u>DEC 29 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please write the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
 13598
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH
 13576

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>11417 Lusterstown Road</u>				d. STREET ADDRESS <u>11417 Lusterstown Road</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Philip Hoffman Knatz</u>				4. DATE OF DEATH Month Day Year <u>December 18 1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 2 1892</u>	9. AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Druggist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward G. Knatz</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Hoffman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-14-5905</u>		17. INFORMANT Address <u>Mrs. Edna Knatz Owings Mills, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis, acute</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>acute</u> DUE TO (c) <u>minutes</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>minutes</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>February 1961</u> to <u>December 18 1961</u> , that (I) (we) last saw the deceased alive on <u>December 18 1961</u> , and that death occurred at <u>8:55 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Clarence E. McWilliams</u>				22b. DATE SIGNED <u>December 18 1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>CLARENCE E. McWILLIAMS</u>				22d. ADDRESS <u>11904 Lusterstown Rd Lusterstown Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Dec. 21, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Henry James Echlaucht Owings Mills</u>				25a. REC'D BY REGISTRAR <u>MD</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinn</u>	

1935

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Wm. I. 212-14-212

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician. Page 5 is retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove section papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13599

CERTIFICATE OF DEATH

13577

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. LENGTH OF STAY in 1b <u>23 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 7</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Veterans Administration Hospital</u>				d. STREET ADDRESS <u>3706 Cedar Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>PETER</u> <u>E.</u> <u>KNIGHT</u>				4. DATE OF DEATH Month <u>December</u> Day <u>29</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>5/21/19</u>	
9. AGE (In years last birthday) <u>42</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Trucking</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Courtland, Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Peter E. Knight</u>				14. MOTHER'S MAIDEN NAME <u>Lelia Bryant</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes</u> <u>WW-11</u>				16. SOCIAL SECURITY NO. <u>226-16-8111</u>			
17. INFORMANT <u>Clinical Records</u>				18. ADDRESS <u>VA Hospital</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOGENIC CARCINOMA WITH METASTASIS</u> <u>162.1</u> <u>met</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u>PNEUMONIA</u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u> <u>2 Days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u> </u> (this hospital) attended the deceased from <u>Dec. 6</u> , 19 <u>61</u> , to <u>Dec. 29</u> , 19 <u>61</u> , that <u> </u> (we) last saw the deceased alive on <u>Dec. 29</u> , 19 <u>61</u> , and that death occurred at <u>6:00</u> p.m. from the causes and on the date stated above.							
22a. SIGNATURE <u>Paul Bormel</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>12/30/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>PAUL BORMEL, M.D.</u>				22d. ADDRESS <u>VAH Balto 18, Md - Ft Howard Division</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/2/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lake View Memorial</u>		23d. LOCATION (City, town or county) (State) <u>Liberty Road, Carroll Co., Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ellsworth Armacost</u>				25a. REC'D BY REGISTRAR <u>JAN 3 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

1953

1953



John F. Jones

1953

RECEIVED

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FOR STATE
HEALTH DEPT.
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2
TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
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MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
13600 13578											
1. PLACE OF DEATH a. COUNTY Baltimore County, MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Baltimore Co.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Texas						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Texas					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Church Lane						d. STREET ADDRESS Church Lane					
3. NAME OF DECEASED (Type or print) CHARLES WINFIELD KONE						4. DATE OF DEATH Month Day Year December 21, 19 61					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAR. 15, 1959		9. AGE (In years last birthday) 2 yrs.		IF UNDER 1 YEAR Months Days 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BABY				10b. KIND OF BUSINESS OR INDUSTRY AT HOME				11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME GREGG KONE						14. MOTHER'S MAIDEN NAME BEATRICE URBIN					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)						16. SOCIAL SECURITY NO. —					
17. INFORMANT FAMILY RECORDS						Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Congestion & Edema 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (b) Myocardial Hypertrophy with Myocardial Failure (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Howard G. Shaub M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED EXAMINER'S NAME (Type) HOWARD G. SHAUB, M. D. DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) 12/21/61											
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF DEC. 23, 1961		22c. NAME OF CEMETERY OR CREMATORY SHERWOOD CEMETERY		22d. LOCATION (City, town, or country) (State) COCKEYSVILLE, MD.					
23. FUNERAL DIRECTOR John Burns' Sons, Towson, Md.						24a. REC'D BY REGISTRAR DEC 29 '61		24b. REGISTRAR'S SIGNATURE John Burns' Sons			

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EX-100
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MAY 1952
BETTER LATER
THAN NEVER

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 Film G302 12/18/61 iwk

1
FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pikesville		c. LENGTH OF STAY in 1b 8		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pikesville		d. STREET ADDRESS 3808 Byfield Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HELEN MARY KRAMER		4. DATE OF DEATH Month December Day 9 Year 1961		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 4, 1933		9. AGE (In years last birthday) 28 yrs.		10. IF UNDER 1 YEAR Months 28 Days 28 Hours 28 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY USA		13. FATHER'S NAME Harry Caplan		14. MOTHER'S MAIDEN NAME Eva Katzoff		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Mr. Gilbert Kramer- 3808 Byfield Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital Heart Disease. 754.5 DUE TO Conditions, if any, which gave rise to immediate cause (b) 754.5 (c) 754.5 (e), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>												INTERVAL BETWEEN ONSET AND DEATH					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12/10/61	
ACTUAL SIGNATURE Charles S. Petty		EXAMINER'S NAME (Type) Charles S. Petty, M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 11/61		22c. NAME OF CEMETERY OR CREMATORY Hebrew Young Men		22d. LOCATION (City, town, or country) (State) Woodlawn, Maryland		23. FUNERAL DIRECTOR Sol. Levinson & Bros. Inc		24a. REC'D BY REGISTRAR DEC 14 '61		24b. REGISTRAR'S SIGNATURE Charles S. Petty	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Baltimore

Thesville

3008 Rutland Avenue

HELEN

MALE

WANDA

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Female

White

May 4, 1953

28

Hutchins

Henry, Georgia

Two children

no

Mr. Gilbert Kennedy 321 E. 1st St.

Congenital Heart Disease.

x _____

x _____

x

12/10/53

Charles A. Jeff, M.D.

Revised: Dec 11/51 Robert Young Man

101. Swinburn & Bros. Inc. 1010 1st St. N.W.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 13580

13602

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Whitemarsh	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hanover Rd.		d. STREET ADDRESS Box 971	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First KATIE Middle KRAMER Last		4. DATE OF DEATH Month December Day 12 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 2, 1879
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frederick Nollenberger		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. INFORMANT Address Walther Berchner, Box 971, Whitemarsh, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Arteriosclerotic Cardio-Vascular Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 hrs. years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-20 , 19 59 , to 12-12- , 19 61 , that I last saw the deceased alive on 11-21 , 19 61 , and that death occurred at 9 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Martin E. Strobel		ADDRESS (Street, city or town, state) 48 Main Street DATE SIGNED 12-12-61	
PHYSICIAN'S NAME (Type) Martin E. Strobel, M.D.		Reisterstown, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 12-15-61	
22c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home, Baltimore, Md.		24a. REC'D BY REGISTRAR DATE DEC 18 '61	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL
ALBANY, N. Y.

1902

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1902

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13603

CERTIFICATE OF DEATH

13581

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster	
3. NAME OF DECEASED (Type or print) First FABIAN Middle EUGENE Last KRIES		d. STREET ADDRESS 133 E. Main St.	
5. SEX Male 6. COLOR OR RACE White		4. DATE OF DEATH Month December Day 30 Year 1961	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 15, 1888 9. AGE (In years last birthday) 72 ? yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Odd Jobs	
11. BIRTHPLACE (County & State, or foreign country) Hanover, Penna		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Kries		14. MOTHER'S MAIDEN NAME Mary Topper	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes give war or dates of service) World War I		16. SOCIAL SECURITY NO. 215-20-7440	
17. INFORMANT Clinical Records address VA Hospital		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROSIS DUE TO (c) ARTERIOSCLEROSIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Unknown Unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Dec. 29 19 61 to Dec. 30 19 61 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Dec. 30 19 61 , and that death occurred at 10:50 M, from the causes and on the date stated above.		22a. SIGNATURE Paul Bormel, M.D. 22b. DATE SIGNED 12/30/61	
22c. PHYSICIAN'S NAME (Type) PAUL BORMEL, M.D.		22d. ADDRESS VAH Balto 18, Md. Fort Howard Division	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/2/62	
23c. NAME OF CEMETERY OR CREMATORY Leisters Cemetery		23d. LOCATION (City, town or county) (State) Westminster Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John E. Meyers ADDRESS Westminster, Maryland		25a. REC'D BY REGISTRAR DATE JAN 3 '62 25b. REGISTRAR'S SIGNATURE William S. Kraus	

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Reg. Dist. No. 3582

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD.		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PARKVILLE		c. LENGTH OF STAY IN 1b XPARKVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8110 HARRIS AVE		d. STREET ADDRESS 8110 HARRIS AVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Samuel Louis Krotee		First Middle Last Samuel Louis Krotee		DATE OF DEATH Month 12 Day 29 Year 1961	
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 9-7-1891		9. AGE (In years lost birthday) yrs. 70		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. School Teacher		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND		11. BIRTHPLACE (State or foreign country) USA	
13. FATHER'S NAME BENJAMIN L. KROTEE		14. MOTHER'S MAIDEN NAME MARY J. BOWERS		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes WWI		16. SOCIAL SECURITY NO. HENRY J. KROTEE		INFORMANT SAME	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 422.1 IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3-4 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 29 Du	
20f. (City or town) 29 Du		(County) 1961		(State) 1961	
21. I certify that I attended the deceased from 29 Du , 19 61 , to 29 Du , 19 61 that I last saw the deceased alive on 29 Du , 19 61 , and that death occurred at 9A M, from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED Arthur S. Krotee					
ACTUAL SIGNATURE Arthur S. Krotee		M.D. Arthur S. Krotee			
PHYSICIAN'S NAME (Type) Arthur S. Krotee					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12/2/62		22c. NAME OF CEMETERY OR CREMATORY DRUID RIDGE Cem.	
22d. LOCATION (City, town, or county) BALTIMORE MD.					
23. FUNERAL DIRECTOR'S SIGNATURE L. J. Ruck		ADDRESS 5305 HARFORD ROAD		24a. REC'D BY REGISTRAR DATE 2 '62	
24b. REGISTRAR'S SIGNATURE Arthur S. Krotee					

TO HOSPITAL OR RETAINING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

VS A15 (4)
15M 9/58

CERTIFICATE OF DEATH

1300

M

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13605

CERTIFICATE OF DEATH

13583

1. PLACE OF DEATH a. COUNTY Baltimore County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
c. LENGTH OF STAY IN 1b 5 mos -		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie 02x-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		d. STREET ADDRESS 3 St. Charles Pl. Marley Pt. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jacob Middle Oda Last Landis		4. DATE OF DEATH Month 12 Day 25 Year 1961	
5. SEX male	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-29-1914
9. AGE (In years last birthday) 47 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber helper		10b. KIND OF BUSINESS OR INDUSTRY Brooks Transf.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Edward Oda Landis		14. MOTHER'S MARDEN NAME Clara Johns	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 216-10-8745	
17. INFORMANT Address Hospital Records, Mt. Wilson State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Stomach DUE TO 151X Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Far adv. Pul. Tuberculosis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-26 19 61 , to 12-25 19 61 , that (I) (we) lost saw the deceased alive on 12-25 19 61 , and that death occurred at 1:30 AM, from the causes and on the date stated above.			
22a. SIGNATURE Wm. Newcomer		22b. DATE SIGNED 12-25-61	
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent		22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 20th Dec. 1961	
23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park		23d. LOCATION (City, town, or county) (State) Glen Burnie Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert P. Ware		25a. REC'D BY REGISTRAR DEC 28 '61 DATE	
ADDRESS Glen Burnie - Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Travis	

50002

REPUBLIC OF BRAZIL

MINISTRY OF AGRICULTURE



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after the death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13606
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13584
CERTIFICATE OF DEATH
Item 9 Film G303 12/19/61 iwr

1. PLACE OF DEATH e. COUNTY Baltimore County Catonsville, Md.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balto	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) St. Josephs Nursing Home,		d. STREET ADDRESS 3602 Harford Road.	
3. NAME OF DECEASED (Type or print) Johanna A. Langhirt		4. DATE OF DEATH Month Dec Day 8 Year 1961	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/11/1882
9. AGE (In years last birthday) 79 8/2 yrs.		IF UNDER 1 YEAR Months 7 Days 2	IF UNDER 24 HRS. Hours 2 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife at home		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Henry Scheper-deceased	
14. MOTHER'S MAIDEN NAME Bertha Hilker -deceased		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT Joseph C. Langhirt-son, 3024 Mayfield Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 422.1 Cerebrovascular accident DUE TO arteriosclerotic cardiovascular d Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)		INTERVAL BETWEEN ONSET AND DEATH 10 d. 15 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 1, 1961 to Dec 8, 1961 ; that (I) (we) last saw the deceased alive on Dec 8, 1961 and that death occurred at 11 PM , from the causes and on the date stated above.			
22a. SIGNATURE James E. Rowe		22b. DATE SIGNED 12/10/61	
22c. PHYSICIAN'S NAME (Type) JAMES E. ROWE		22d. ADDRESS 1011 Frederick Rd #28 Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/12/1961	
23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		23d. LOCATION (City, town or county) (State) Belair Rd.	
24. FUNERAL DIRECTOR'S SIGNATURE C. Schimunek		25a. REC'D BY REGISTRAR DATE DEC 13 '61	
25b. REGISTRAR'S SIGNATURE John S. Harris			

C. Schinunek 2331 Thomas Lane

Christ 12/12/1901 Holy Redeemer

Belair Md.

JAMES E. Rowe

James E. Rowe

Dec 7, 1901

Jan 1, 1902

Dec 1, 1901

Belair Md.

Christ 12/12/1901 Holy Redeemer

Belair Md.

JAMES E. Rowe

James E. Rowe

Dec 7, 1901

Jan 1, 1902

Dec 1, 1901

no

no

none

Joseph C. Langhitt-son, 3024 Myrtle Ave

Henry Scherger-deceased

Bertus Hiker-deceased

Housewife at home none

Baltimore, Md.

U.S.A.

Female white

X

2/11/1882

1882

Johanna A. Langhitt

Dec 2, 1901

2602 Harford Road

St. Josephs Nursing Home

Balto

Catonville, Md.

Md.

1902

1902

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13385

13607

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN lb 2 Days				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4 d. STREET ADDRESS 1721 W. Joppa Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GEORGE Middle R. Last LASHER				4. DATE OF DEATH Month December Day 19 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 22, 1931 30 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Chemical Company		11. BIRTHPLACE (County & State, or foreign country) Brooklandville, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Robert W. Lasher				14. MOTHER'S MAIDEN NAME Gladys Justice			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 216-28-6272		17. INFORMANT Address Clinical Records, VAH, Baltimore 18, Maryland Fort Howard Division			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RETROPERITONEAL SARCOMA WITH METASTASES TO LUNGS, LIVER, ADRENALS, LEFT KIDNEY AND PERITONEAL CAVITY Conditions, if any, which gave rise to immediate cause (b) UNKNOWN (a), stating the underlying cause last. (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from Dec. 17, 1961 , to Dec. 19, 1961 , that (X) (we) last saw the deceased alive on Dec. 19, 1961 , and that death occurred at 3:00 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Sebastian Russo M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 12/20/61	
22c. PHYSICIAN'S NAME (Type) SEBASTIAN RUSSO, M.D.				22d. ADDRESS VAH, BALTO 18 MD. FTHOWARD DIVISION			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF DEC. 23, 1961		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Memorial		23d. LOCATION (City, town or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons Funeral Home, Baltimore, Md.				25a. REC'D BY REGISTRAR DEC 29 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 1 of this certificate may be retained by the hospital or attending physician. Page 2 of this certificate may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

15007

(M)

(T)

610 York Road
Baltimore, Md.

Agency Valued Insurance

Division

Wm. H. Hays, Jr., President

REC-111

15007

Company #

First National

First National Bank

First National Bank

Branch

Branch

Branch

Branch

Branch

U. S. A.

Branch

Branch

Branch

Branch

Branch

Branch

Branch

Doc. #

Doc. #

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Doc. #

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13608

13586

FOR STATE
HEALTH DEPT.

M

TO: DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22)		c. LENGTH OF STAY IN 1b 6 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Dundalk (22)		d. STREET ADDRESS 7509 Belmont Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 7509 Belmont Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CLEON Middle MARTIN Last LEASE				4. DATE OF DEATH Month December Day 31 Year 19 61			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 26, 1898	
9. AGE (In years last birthday) 63		IF UNDER 1 YEAR Months 63 Days 63 Hours 63 Min. 63		9. AGE (In years last birthday) 63		IF UNDER 24 HRS. Months 63 Days 63 Hours 63 Min. 63	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian		10b. KIND OF BUSINESS OR INDUSTRY Public School		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas F. Lease				14. MOTHER'S MAIDEN NAME Sarah Hill			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		16. SOCIAL SECURITY NO. 213-01-4159		17. INFORMANT Estelle G. Lease		Address same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CH of Pt. Lung DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO (c) </p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None </p> </div> <div style="width: 15%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH 9 M.C.S.</p> </div> </div>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) None					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE M B Davis				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Melvin B. Davis, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 1/4/62		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	
23. FUNERAL DIRECTOR Walter Brooks Bradley, Inc., Dundalk 22, Md.				22d. LOCATION (City, town, or country) (State) Baltimore, Maryland		24a. REGISTRY BY REGISTRAR JAN 5 1962	
24b. REGISTRAR'S SIGNATURE Walter Brooks Bradley, Inc.				DATE SIGNED 1/2/62			

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

13609

CERTIFICATE OF DEATH

13587

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Harford</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Towson</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Bel Air</u>	<u>12 X 2</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Towson Convalescent 301 W. Chesapeake</u>		STREET ADDRESS (If rural give location) <u>Old Joppa Road</u>	
3. NAME OF DECEASED (Type or Print) <u>David Lee</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>12 14 19 61</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>October 27, 1873</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>	9. AGE last birthday <u>88</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ralph Lee</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Amos</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT & ADDRESS (Wife) <u>Mrs. Linda M. Lee</u>		<u>Box 146</u> <u>Bel Air, Maryland</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
332X IMMEDIATE CAUSE (A) <u>Respiratory Failure</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Epilepsy (cerebral)</u>			<u>5 days</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arterio Sclerosis, Generalized</u>			<u>20 yrs</u>
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Dec 2</u> , 19 <u>61</u> , to <u>Dec 14</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>12/14</u> , 19 <u>61</u> , and that death occurred at <u>7:20 P.</u> M, from the causes and on the date stated above.			
SIGNATURE <u>For H. S. Slack</u>		ADDRESS (Street, city, town, state) <u>200 W. Penn. Ave. Towson, Md.</u>	
DATE <u>12/15/61</u>		DATE SIGNED <u>12/15/61</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 17, 1961</u>	
NAME OF CEMETERY OR CREMATORY <u>LITTLE FALLS FRIENDS CEM.</u>		LOCATION (City, town, or county) (State) <u>Fallston, Harf. Co., Maryland</u>	
24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u>	
REGISTRAR'S SIGNATURE <u>James S. Evans</u>		ADDRESS <u>W. Broadway + Williams St. Bel Air, Maryland</u>	

CERTIFICATE OF DEATH

1908

1. NAME OF DECEASED

JOHN J. SMITH

2. SEX

MALE

3. AGE

45

4. PLACE OF BIRTH

NEW YORK

5. OCCUPATION

LABORER

6. DATE OF DEATH

10/15/08

7. CAUSE OF DEATH

HEART DISEASE

8. PLACE OF DEATH

HOME

9. SIGNATURE OF PHYSICIAN

J. J. SMITH

10. SIGNATURE OF REGISTRAR

J. J. SMITH

11. SIGNATURE OF WITNESSES

J. J. SMITH

12. SIGNATURE OF DECEASED

J. J. SMITH

13. SIGNATURE OF DECEASED

J. J. SMITH

14. SIGNATURE OF DECEASED

J. J. SMITH

15. SIGNATURE OF DECEASED

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16. SIGNATURE OF DECEASED

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17. SIGNATURE OF DECEASED

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18. SIGNATURE OF DECEASED

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19. SIGNATURE OF DECEASED

J. J. SMITH

20. SIGNATURE OF DECEASED

J. J. SMITH

21. SIGNATURE OF DECEASED

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22. SIGNATURE OF DECEASED

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23. SIGNATURE OF DECEASED

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40. SIGNATURE OF DECEASED

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41. SIGNATURE OF DECEASED

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42. SIGNATURE OF DECEASED

J. J. SMITH

43. SIGNATURE OF DECEASED

J. J. SMITH

44. SIGNATURE OF DECEASED

J. J. SMITH

45. SIGNATURE OF DECEASED

J. J. SMITH

46. SIGNATURE OF DECEASED

J. J. SMITH

47. SIGNATURE OF DECEASED

J. J. SMITH

48. SIGNATURE OF DECEASED

J. J. SMITH

ENCLOSURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within _____ hours after death. Page _____ may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Titen please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13610

13588

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Ma. b. COUNTY ✓	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN 1b 3 Months		d. STREET ADDRESS 317 N. Payson St.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Shady Nook Home, 1002 N. Rolling Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lula		4. DATE OF DEATH Dec. 18, 1961	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 26, 1885	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Baltimore	
11. BIRTHPLACE (County & State, or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? Unknown	
13. FATHER'S NAME Frederick Gronemeyer		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Margaret McDonald		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial failure. DUE TO (b) Antisepsis Cardia-vascular disease. DUE TO (c) Bronchial pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH 3 days 1 week	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from Sept. 1961 to Dec. 18, 1961 , that (I) (we) last saw the deceased alive on Dec. 18, 1961 , and that death occurred at 11 P.M. from the causes and on the date stated above.			
22a. SIGNATURE D. C. MacLaughlin		22b. DATE SIGNED _____	
22c. PHYSICIAN'S NAME (Type) D. C. MacLaughlin		22d. ADDRESS 4508 Edmondson Ave.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-21-61	
23c. NAME OF CEMETERY OR CREMATORY Western		23d. LOCATION (City, town or county) _____ (State) _____ Baltimore	
24. FUNERAL DIRECTOR'S SIGNATURE Fred A. Cole		25a. REC'D BY REGISTRAR DEC 22 '61	
ADDRESS 1913 N. Balto. St.		25b. REGISTRAR'S SIGNATURE Arthur S. Perna	

1961

Ontarioville

Shirley Anne Rose, 1904 E. Highway 10, 117 N. Taylor St.

Female, 1911, 1904 E. Highway 10, 117 N. Taylor St.

Robert, 1911, 1904 E. Highway 10, 117 N. Taylor St.

Frederick, 1911, 1904 E. Highway 10, 117 N. Taylor St.

Robert, 1911, 1904 E. Highway 10, 117 N. Taylor St.

1904 E. Highway 10, 117 N. Taylor St.

1911, 1904 E. Highway 10, 117 N. Taylor St.

1911, 1904 E. Highway 10, 117 N. Taylor St.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 1 of 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13611

13589

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cockeysville,</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Masonic Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> d. STREET ADDRESS <u>67 Burke Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary</u> First <u>Catherine</u> Middle <u>Loose</u> Last 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Dec 18, 1869</u> 9. AGE (In years last birthday) <u>92</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		4. DATE OF DEATH <u>Dec 29</u> 19 <u>61</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>August Loose</u> 14. MOTHER'S MAIDEN NAME <u>Elizabeth (Unknown)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service) 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Frank L. Smith</u> Address <u>Masonic Home, Cockeysville</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral bronchopneumonia</u> 450.0 DUE TO (b) <u>Generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Diabetes Mellitus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>year</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 19</u> , 19 <u>61</u> , to <u>Dec 29</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Dec 29</u> , 19 <u>61</u> , and that death occurred at <u>1:30</u> PM, from the causes and on the date stated above.			
22a. SIGNATURE <u>Elizabeth B. Shennill</u> M.D. 22b. DATE SIGNED		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>Elizabeth B. Shennill MD</u>		22d. ADDRESS <u>Cockeysville Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Jan. 2, 1962</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u> 23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>			
24 FUNERAL DIRECTOR'S SIGNATURE <u>William Cook, Inc.</u> ADDRESS <u>1217 St. Paul Street</u> 25a. REC'D BY REGISTRAR <u>JAN 3 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>			

VR A15 (4)
15M 9/60

M

1961

CERTIFICATE OF BIRTH

1961

COCKEY, William

His name is

William

COCKEY, William

Honorable

Honorable

Honorable

Frank I. Smith

Honorable

COCKEY, William

1961

COCKEY, William

COCKEY, William

COCKEY, William

COCKEY, William

COCKEY, William

London Park Co.

1217 St. Paul Street

William Cook, Inc.

Honorable

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
m. retained in hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13612

13590

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		c. LENGTH OF STAY IN 1b 3001-4		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY BALTIMORE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital				d. STREET ADDRESS 3636 ROLAND AVENUE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HARRY		First THOMAS		Middle LOWE		Last LOWE		4. DATE OF DEATH Month 12 - Day 10 - Year 1961	
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 7-19-1896		9. AGE (In years last birthday) 65 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LANDSCAPER		10b. KIND OF BUSINESS OR INDUSTRY LANDSCAPING		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A			
13. FATHER'S NAME THOMAS LOWE				14. MOTHER'S MAIDEN NAME ALICE M. HANN					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 15-073427		17. INFORMANT Address Hospital Records, Mt. Wilson State Hospital					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LUNG, BRONCHOGENIC WITH METASTASES 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 5 MONTHS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 8-3-1961 to 12-10-1961 , that (I) (we) last saw the deceased alive on 12-10-1961 , and that death occurred at 9:00 P.M. from the causes and on the date stated above.									
22a. SIGNATURE Wm. Newcomer				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE 12-10-61 SIGNED			
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M. D. Superintendent				22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12-14-61		23c. NAME OF CEMETERY OR CREMATORY GREENMOUNT		23d. LOCATION (City, town, or county) GREENMOUNT CARROLL Md (State)			
24. FUNERAL DIRECTOR'S SIGNATURE Frank H. Seitz				ADDRESS 8142 36th St		25a. REC'D BY REGISTRAR DATE DEC 13 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

100-100000

OFFICE OF THE ATTORNEY GENERAL

100-100000

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13613

CERTIFICATE OF DEATH

Item & Film G303 12/22/61 mh

13591

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS <u>523 Nottingham Road #29</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>2119 Edmondson Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Lillian</u> Middle <u>M.</u> Last <u>Lowe</u>				4. DATE OF DEATH Month <u>December</u> Day <u>16</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1880</u> <u>Sept. 22, 1880</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		10. UNDER 1 YEAR		11. UNDER 24 HRS.		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>			
13. FATHER'S NAME <u>? English</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Connelly</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>(If yes give war or dates of service)</u>			
17. INFORMANT <u>Mrs. R. Stewart Benson-2119 Edmondson Ave-#28</u>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> 4 4 4 X DUE TO (b) <u>Arterio-sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>Hypertension - severe</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>year</u> <u>year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 1957</u> to <u>Dec 16, 1961</u> , that (I) (we) last saw the deceased alive on <u>Dec. 16, 1961</u> , and that death occurred at <u>1:27 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Wetherbee Fort</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Wetherbee Fort</u>				22d. ADDRESS <u>1118 St. Paul St. Baltimore, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-19-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tucker & Sons Baltimore 12, Md.</u>				25a. REC'D BY REGISTRAR <u>DEC 18 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. Page 4 of this certificate has been signed by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1808

1808

(1)

(1)

Received of the
Honble. Secy. of State
the sum of \$1000

for the purchase of
the land

Witness my hand and seal
this 22nd day of June 1808
at the City of New York

13
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13614

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13592

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore Co.	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore (rural)		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore (rural)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 2517 Hammonds Ferry Road		d. STREET ADDRESS 2517 Hammonds Ferry Road	
3. NAME OF DECEASED (Type or print) First JAMES Middle EMORY Last LOWRY		4. DATE OF DEATH Month December Day 23 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 17, 1925
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) salesman		10b. KIND OF BUSINESS OR INDUSTRY Maryland	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME James Emory Lowry, Sr.		14. MOTHER'S MAIDEN NAME Charlotte M. Reed	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes WWII		16. SOCIAL SECURITY NO. 213-20-7778	
17. INFORMANT Howard Thorn		Address 2507 Brohawn Ave. #30	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of head and brain. 976X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Gunshot wound in right temple.	
20c. TIME OF INJURY Month, Day, Year 4:30 a.m. 12/23/19 61		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Baltimore Co., Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Howard H. Hubbard		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) HOWARD G. SHAUB, M. D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
		Address (Street, city, town, or county) 12/23/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/26/61	22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem. Baltimore, Maryland	22d. LOCATION (City, town, or country) (State)
23. FUNERAL DIRECTOR Howard H. Hubbard 4107 Wilkens Ave.		24a. REC'D BY REGISTRAR DEC 28 '61	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

Howard H. Hubbard 4107 Wilkens Ave.

12/1/41

Elmore National Cem. Baltimore, Md.

Unknown record in this family.

12/1/41

James R. Roney, Sr.

(Charles M. Roney)

Elmore

Baltimore

12/1/41

317 Kammocke Mary Road

Baltimore (Md.)

13615

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13593

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY AnneArundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland				c. LENGTH OF STAY IN 1b 57 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last NETTIE REBECCA MARTZ				4. DATE OF DEATH Month Day Year Dec 22 1961			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-11-1898	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wm F. Sterling				14. MOTHER'S MAIDEN NAME Estelle Butler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Hospital Records, Mt. Wilson State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tuberculosis of Bone 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) Pulmonary tuberculosis. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 yrs. 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Mar. 15, 1961 , to Dec 22, 1961 , that (I) (we) last saw the deceased alive on Dec 22, 1961 , and that death occurred at 9⁴⁵ AM , from the causes and on the date stated above.							
22a. SIGNATURE W. Newcomer				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> Dec. 22, 1961		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Print) Wm. Newcomer, M.D., Superintendent				22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.			
23a. BURIAL, CREMATION, or REMOVAL (Specify) Burial		23b. DATE THEREOF 26 Dec. 1961		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park		23d. LOCATION (City, town, or county) (State) Glen Burnie, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Richard V. Singleton				25a. REC'D BY REGISTRAR Glen Burnie, Md.		25b. REGISTRAR'S SIGNATURE Claudia S. House	

13612

13612

AMERICAN AIR MAIL SERVICE
UNITED STATES DEPARTMENT OF POSTS
WASHINGTON, D. C.

CERTIFICATE OF DELIVERY

Post Office at New York, N. Y.

Post Office at New York, N. Y.

RECEIVED AIR MAIL

Post Office at New York, N. Y.

Post Office at New York, N. Y.

Post Office at New York, N. Y.

Post Office at New York, N. Y.

Post Office at New York, N. Y.

Post Office at New York, N. Y.

Post Office at New York, N. Y.

Post Office at New York, N. Y.

Post Office at New York, N. Y.

Post Office at New York, N. Y.

Post Office at New York, N. Y.

Post Office at New York, N. Y.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13616 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13594

1
 FOR STATE HEALTH DEPT.
 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, except in cases of sudden death, when it may be executed at any time. The certificate should be executed by the medical examiner, or his designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. The certificate should be executed in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.) Dundalk (22) c. LENGTH OF STAY in lb 17 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9 Broadship Road				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22) d. STREET ADDRESS 9 Broadship Road a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) EFFIE JANE McCAIN			4. DATE OF DEATH Month Day Year December 25, 1961				
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 28, 1877	9. AGE (In years last birthday) 84 yrs. IF UNDER 1 YEAR: Months Days Hours Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		
10b. KIND OF BUSINESS OR INDUSTRY Housewife			11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Oliver Handley			14. MOTHER'S MAIDEN NAME Charlotte ???				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give year or dates of service)		16. SOCIAL SECURITY NO. none	17. INFORMANT Address Mrs. Bessie Wilkerson same as #2				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO AN S-C-V-DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Senility DUE TO (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH 		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Melvin B. Davis, M.D. DATE SIGNED 12/26/61 EXAMINER'S NAME (Type) Melvin B. Davis, M.D. Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/29/61	22c. NAME OF CEMETERY OR CREMATORY Dale Cemetery		22d. LOCATION (City, town, or country) (State) Connersville, Indiana			
23. FUNERAL DIRECTOR ADDRESS Walter Brooks Bradley, Inc., Dundalk 22, Md.			24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR DURING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
The deceased was retained in the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

13617

CERTIFICATE OF DEATH

13595

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN 1b <u>8 years, 6 months, 16 days</u>		d. STREET ADDRESS <u>3225 Rosalie Road - Formerly of</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ella Mae May</u> <u>Mc Cullough</u>		4. DATE OF DEATH Month Day Year <u>December 3 1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-2-79</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Brown</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Edwards</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Records: Spring Grove State Hospital</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>10 years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>5/17</u> 19 <u>55</u> to <u>12/3</u> 19 <u>61</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>12/3</u> 19 <u>61</u> , and that death occurred at <u>8:00</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Maurice J. Van Besien</u> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED <u>12/3/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>MAURICE J. VAN BESIE</u>		22d. ADDRESS <u>SPRING GROVE ST. HOSP.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-6-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Jackson & Son - North & Perry Ave</u> ADDRESS <u>Baltimore, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 4 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Wm. J. Jackson</u>			

20-21

UNITED STATES

5181



TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after the death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

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2

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
13618					13596									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)									
a. COUNTY Baltimore					a. STATE Maryland									
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard					b. COUNTY Anne Arundel									
c. LENGTH OF STAY IN 1b 13 Days					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Annapolis									
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital					d. STREET ADDRESS 75 Northwest Street									
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH									
First Middle Last CRAWFORD Alexander A. McPHERSON					Month Day Year December 19 19 61									
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 27, 1922		9. AGE (in years last birthday) 39 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender		10b. KIND OF BUSINESS OR INDUSTRY Liquor		11. BIRTHPLACE (County & State, or foreign country) Annapolis, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
13. FATHER'S NAME Crawford McPherson					14. MOTHER'S MAIDEN NAME Fredretha Parker									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II					16. SOCIAL SECURITY NO. 216-18-5924					17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland Fort Howard Division				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								INTERVAL BETWEEN ONSET AND DEATH						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC GLOMERULONEPHRITIS								UNKNOWN						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 592X LEFT VENTRICULAR HYPERTROPHY								UNKNOWN						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
Bronchial Aspiration. Pulmonary Edema.														
20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Dec. 6 , 19 61 , to Dec. 19 , 19 61 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Dec. 19 , 19 61 , and that death occurred at 3:15 M., from the causes and on the date stated above.														
22a. SIGNATURE Sebastian Russo					22b. DATE SIGNED 12/20/61									
22c. PHYSICIAN'S NAME (Type) SEBASTIAN RUSSO, M.D.					22d. ADDRESS VAH, BALTO 18 MD FT. HOWARD DIVISION									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF 12-22-61									
23c. NAME OF CEMETERY OR CREMATORY Brewer Hill Cemetery					23d. LOCATION (City, town or county) (State) Annapolis, Maryland									
24. FUNERAL DIRECTOR'S SIGNATURE Charles Hicks, 45 Northwest St. Anna;olis, Md.					25a. REC'D BY REGISTRAR DEC 27 '61									
					25b. REGISTRAR'S SIGNATURE Charles S. Hicks									

1961

OFFICE OF THE

1961

Belmont, J. Edgar

John Edgar Hoover

Director of Federal Bureau of Investigation

Washington, D.C.

January 1, 1961

Dear Sir:

Reference is made to your letter of December 15, 1960.

Enclosed for the Bureau are two copies of the report of the

Committee on the Assassination of President John F. Kennedy.

Very truly yours,

J. Edgar Hoover

Director

Enclosure

Very truly yours,

J. Edgar Hoover

Director

Enclosure

Very truly yours,

J. Edgar Hoover

Director

Enclosure

Very truly yours,

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 are to be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13619

13597

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garrison		c. LENGTH OF STAY IN 20 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garrison			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Kenmar Ave.				d. STREET ADDRESS Kenmar Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Norman		First L. Middle Meekins Last		4. DATE OF DEATH Dec. 23, 1961		Month Dec. Day 23 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 16, 1891		9. AGE (In years last birthday) 70 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Warehouse Foreman		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joshua Meekins				14. MOTHER'S MAIDEN NAME Lillie Cornthwaile			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-01-9199		17. INFORMANT William J. Meekins		Address Reisterstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma DUE TO Carcinoma of the prostate Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 177X (b) 177X (c) 177X						INTERVAL BETWEEN ONSET AND DEATH 5 yrs. 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) none					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. none 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> none		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) none	
21. I certify that (I) (the physician) attended the deceased from 9-6-50 , 19 60 , to 12-23-61 , 19 61 ; that (I) (the physician) last saw the deceased alive on 12-21-61 , 19 61 , and that death occurred at 11 A.M. from the causes and on the date stated above.							
22a. SIGNATURE D. D. Caples M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12-26-61	
22c. PHYSICIAN'S NAME (Type) D. D. Caples, M. D.				22d. ADDRESS 6 Hanover Rd., Reisterstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 26, 1961		23c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery		23d. LOCATION (City, town or county) (State) Randallstown Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. F. Eline & Sons				ADDRESS Reisterstown, Md.		25a. REC'D BY REGISTRAR DEC 27 '61	
				25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanna</i>			

1961

DEPARTMENT OF DEFENSE

OFFICE OF THE SECRETARY OF DEFENSE

MEMORANDUM FOR THE SECRETARY OF DEFENSE
SUBJECT: [Illegible]
DATE: [Illegible]
FROM: [Illegible]
TO: [Illegible]
[The remainder of the document contains several paragraphs of text that are illegible due to extreme fading and poor image quality.]

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL RECORDS
OFFICE OF THE REGISTRAR
ALBANY, N. Y.
JAN 10 1908

NEW YORK
JAN 10 1908

Birth of child
Name of child
Date of birth

Signature of Registrar
Date of registration
Official Seal

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13621

13599

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills c. LENGTH OF STAY IN b 10 1/2 months d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rosewood State Training School				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Garrett c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grantsville d. STREET ADDRESS Route 1 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Elizabeth Gene Messenger		4. DATE OF DEATH 12 7 19 61		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 4/9/44 9. AGE (In years last birthday) 17 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) dependent 10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (County, State, or foreign country) Fairmont, Marion, W. Va. Garrett Co., Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Jack Glenn Messenger 14. MOTHER'S MAIDEN NAME Juanita Marie Wright Messenger			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. none		17. INFORMANT Rosewood Records, Owings Mills, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BILATERAL BRONCHOPNEUMONIA DUE TO ATROPHY OF PONS + CEREBELLUM Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Internal Hydrocephalus Etiology undetermined							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (H) (this hospital) attended the deceased from 1/19 , 19 61 to 12/7 , 19 61 , that (H) (we) last saw the deceased alive on 12/7 , 19 61 , and that death occurred at 4:10 p.m. the causes and on the date stated above.							
22a. SIGNATURE 22c. PHYSICIAN'S NAME (Type) Harry G. Butler, M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS Rosewood Lane, Owings Mills, Md.		22b. DATE SIGNED 12/8/61			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF 12/11/61 23c. NAME OF CEMETERY OR CREMATORY BEVERLY MEMORIAL GARDENS, MORGANTOWN 23d. LOCATION (City, town or county) (State) W. Va.		24. FUNERAL DIRECTOR'S SIGNATURE Doyle Newman, Grantsville, Md. 25a. REC'D BY REGISTRAR DEC 13 '61 25b. REGISTRAR'S SIGNATURE					

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1970

CERTIFICATE OF MARRIAGE

1970

Gravesville

1970

Gravesville

Gravesville

Gravesville

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1 FOR STATE HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13622 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13600

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rogers Forge				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Gwynn Oak			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS 3614 Howard Park Avenue			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) York & Dumbarton Roads				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES STANLEY MICHAEL				4. DATE OF DEATH Month Day Year December 30 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 9, 1905	
9. AGE (In years last birthday) 56 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales man		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles H. Michael				14. MOTHER'S MAIDEN NAME Fannie Cross			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. 216-07-8190			
17. INFORMANT Kathryn A. Michael				Address 36 14 Howard Park Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease. DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 422.1 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 1/3/62 22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery 22d. LOCATION (City, town, or country) (State) Baltimore, Maryland 23. FUNERAL DIRECTOR Ellsworth Armacost ADDRESS 4600 Liberty Hgts. Ave. 24a. REC'D BY REGISTRAR JAN 3 '62 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanes</i>							

MEDICAL CERTIFICATION



4. 2007 年 10 月 1 日起实施

TO HOSPITAL OR A ...
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

Page 4

hours after death

hours after death

hours after death

hours after death

hours after death

hours after death

hours after death

hours after death

hours after death

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13623

CERTIFICATE OF DEATH

Reg. Dist. No. 13601

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Pikesville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Professional House		d. STREET ADDRESS 11 Slade Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LOUIS Middle B. Last MICHELSON		4. DATE OF DEATH Month December Day 2 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB 14, 1886
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Mfg- Cigars	
11. BIRTHPLACE (State or foreign country) London, England		12. CITIZEN OF WHAT COUNTRY? RUSSIA USA	
13. FATHER'S NAME Simon Michelson		14. MOTHER'S MAIDEN NAME Elka ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no	
INFORMANT Mrs. Leonard Forman- 7929 Longmeadow Rd.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/1 , 19 55 , to 12/1 , 19 61 , that I last saw the deceased alive on 12/1 , 19 61 , and that death occurred at 11 A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Daniel Wilfson M.D. 5721 York Road PHYSICIAN'S NAME (Type) Dr/ Daniel Wilfson Boettcher 15-111			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 3/61	
22c. NAME OF CEMETERY OR CREMATORY Hebrew Friendship		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Sol. Levinson & Bros. Inc. 6010 Reisterstown Rd.		24a. REC'D BY REGISTRAR DEC 6 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

[illegible]

105-10

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13602

13624

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAPE MAY BEACH				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 426 KATHERINE AVE.				e. STREET ADDRESS 426 Katherine Ave.			
3. NAME OF DECEASED (Type or print) First SAM Middle MIDDLETON Last				4. DATE OF DEATH Month DEC Day 27 Year 1961 19			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 23, 1892	
9. AGE (In years last birthday) 69 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Anderson County S.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Sam Middleton		14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 1913 TO 1945		16. SOCIAL SECURITY NO. 212 26 9082		17. INFORMANT 426 Katherine Avenue Mrs Frances J. Middleton			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 H-S-C-V-Disease DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) None					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE M B Davis				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) M B Davis MD				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/30/61		22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem. Baltimore Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Henry Sander & Sons Inc. Baltimore MD.				24a. REC'D BY REGISTRAR JAN 2 '62		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

Page 4
hours after death
The law requires that the death certificate be executed within 72 hours after death.
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13603

13625

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> c. LENGTH OF STAY IN 1b <u>Baltimore</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in the Pines Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u> d. STREET ADDRESS <u>1716 Langford Road #7</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>R.</u> Last <u>Mikulski</u>		4. DATE OF DEATH Month <u>12</u> Day <u>7</u> Year <u>61</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 13, 1902</u>
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Short Order-Cook (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Nanticoke, Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Thomas Stegura</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>203-05-7887</u>	
17. INFORMANT <u>Mrs. Dolores A. Moore-1716 Langford Rd.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO <u>171X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic Carcinoma</u> (c) <u>Carcinoma of Cervix</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>3 days</u> <u>1 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12-6-1951</u> to <u>12-7-1961</u> , that (I) (we) last saw the deceased alive on <u>12-7-1961</u> , and that death occurred at <u>24 hr</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Wilbur K. Gallager</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Wilbur K. Gallager</u>		22d. ADDRESS <u>6209 Frederick Ave., Catonsville 28, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-11-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Holy Trinity</u>		23d. LOCATION (City, town, or county) (State) <u>Nanticoke, Pennsylvania</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tucker & Sons</u>		25a. REC'D BY REGISTRAR <u>DEC 8 '61</u>	
ADDRESS <u>Belts. 17, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. House</u>	

13852

STATE OF TEXAS

13852



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 13604

13626

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b 9 Weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Res., 1734 Melbourne Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ALICE First MILLER Middle Last		4. DATE OF DEATH December 16 Year 1961 Month Day	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 7, 1884
9. AGE (In years last birthday) 77 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry Beatty		14. MOTHER'S MAIDEN NAME Mary Cassell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT Mrs. Alma Bleach		Address 2841 Roborn Avenue	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident (CVA) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH. immed.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from DEC 15, 1961 to DEC 16, 1961 , that I last saw the deceased alive on DEC 15, 1961 and that death occurred at 6 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 7538 HOLABIRD AVE. BALTO. 22, MD. DATE SIGNED 12-18-61 ACTUAL SIGNATURE Leonard M. Zullo M.D. PHYSICIAN'S NAME (Type) LEONARD M. ZULLO BALTO. 22, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-19-1961	22c. NAME OF CEMETERY OR CREMATORY Schwartz Cemetery	22d. LOCATION (City, town, or county) (State) O'Donnell St. Md.
23. FUNERAL DIRECTOR'S SIGNATURE JOHN J. DUDA ADDRESS 7922 Wise Ave. 22, Md.		24a. REC'D BY REGISTRAR DEC 21 '61	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. It is to be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED _____</p>		<p>2. SEX _____</p>	
<p>3. AGE _____</p>		<p>4. DATE OF BIRTH _____</p>	
<p>5. PLACE OF BIRTH _____</p>		<p>6. DATE OF DEATH _____</p>	
<p>7. TIME OF DEATH _____</p>		<p>8. PLACE OF DEATH _____</p>	
<p>9. CAUSE OF DEATH _____</p>		<p>10. MANNER OF DEATH _____</p>	
<p>11. SIGNATURE OF PHYSICIAN _____</p>		<p>12. SIGNATURE OF REGISTRAR _____</p>	
<p>13. SIGNATURE OF WITNESS _____</p>		<p>14. SIGNATURE OF DECEASED _____</p>	
<p>15. SIGNATURE OF NEXT OF KIN _____</p>		<p>16. SIGNATURE OF BURIAL OFFICIAL _____</p>	
<p>17. SIGNATURE OF CHURCH OFFICIAL _____</p>		<p>18. SIGNATURE OF FUNERAL HOME _____</p>	
<p>19. SIGNATURE OF CEMETERY OFFICIAL _____</p>		<p>20. SIGNATURE OF INTERVIEWER _____</p>	
<p>21. SIGNATURE OF INTERVIEWER _____</p>		<p>22. SIGNATURE OF INTERVIEWER _____</p>	
<p>23. SIGNATURE OF INTERVIEWER _____</p>		<p>24. SIGNATURE OF INTERVIEWER _____</p>	
<p>25. SIGNATURE OF INTERVIEWER _____</p>		<p>26. SIGNATURE OF INTERVIEWER _____</p>	
<p>27. SIGNATURE OF INTERVIEWER _____</p>		<p>28. SIGNATURE OF INTERVIEWER _____</p>	
<p>29. SIGNATURE OF INTERVIEWER _____</p>		<p>30. SIGNATURE OF INTERVIEWER _____</p>	
<p>31. SIGNATURE OF INTERVIEWER _____</p>		<p>32. SIGNATURE OF INTERVIEWER _____</p>	
<p>33. SIGNATURE OF INTERVIEWER _____</p>		<p>34. SIGNATURE OF INTERVIEWER _____</p>	
<p>35. SIGNATURE OF INTERVIEWER _____</p>		<p>36. SIGNATURE OF INTERVIEWER _____</p>	
<p>37. SIGNATURE OF INTERVIEWER _____</p>		<p>38. SIGNATURE OF INTERVIEWER _____</p>	
<p>39. SIGNATURE OF INTERVIEWER _____</p>		<p>40. SIGNATURE OF INTERVIEWER _____</p>	
<p>41. SIGNATURE OF INTERVIEWER _____</p>		<p>42. SIGNATURE OF INTERVIEWER _____</p>	
<p>43. SIGNATURE OF INTERVIEWER _____</p>		<p>44. SIGNATURE OF INTERVIEWER _____</p>	
<p>45. SIGNATURE OF INTERVIEWER _____</p>		<p>46. SIGNATURE OF INTERVIEWER _____</p>	
<p>47. SIGNATURE OF INTERVIEWER _____</p>		<p>48. SIGNATURE OF INTERVIEWER _____</p>	
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<p>51. SIGNATURE OF INTERVIEWER _____</p>		<p>52. SIGNATURE OF INTERVIEWER _____</p>	
<p>53. SIGNATURE OF INTERVIEWER _____</p>		<p>54. SIGNATURE OF INTERVIEWER _____</p>	
<p>55. SIGNATURE OF INTERVIEWER _____</p>		<p>56. SIGNATURE OF INTERVIEWER _____</p>	
<p>57. SIGNATURE OF INTERVIEWER _____</p>		<p>58. SIGNATURE OF INTERVIEWER _____</p>	
<p>59. SIGNATURE OF INTERVIEWER _____</p>		<p>60. SIGNATURE OF INTERVIEWER _____</p>	
<p>61. SIGNATURE OF INTERVIEWER _____</p>		<p>62. SIGNATURE OF INTERVIEWER _____</p>	
<p>63. SIGNATURE OF INTERVIEWER _____</p>		<p>64. SIGNATURE OF INTERVIEWER _____</p>	
<p>65. SIGNATURE OF INTERVIEWER _____</p>		<p>66. SIGNATURE OF INTERVIEWER _____</p>	
<p>67. SIGNATURE OF INTERVIEWER _____</p>		<p>68. SIGNATURE OF INTERVIEWER _____</p>	
<p>69. SIGNATURE OF INTERVIEWER _____</p>		<p>70. SIGNATURE OF INTERVIEWER _____</p>	
<p>71. SIGNATURE OF INTERVIEWER _____</p>		<p>72. SIGNATURE OF INTERVIEWER _____</p>	
<p>73. SIGNATURE OF INTERVIEWER _____</p>		<p>74. SIGNATURE OF INTERVIEWER _____</p>	
<p>75. SIGNATURE OF INTERVIEWER _____</p>		<p>76. SIGNATURE OF INTERVIEWER _____</p>	
<p>77. SIGNATURE OF INTERVIEWER _____</p>		<p>78. SIGNATURE OF INTERVIEWER _____</p>	
<p>79. SIGNATURE OF INTERVIEWER _____</p>		<p>80. SIGNATURE OF INTERVIEWER _____</p>	
<p>81. SIGNATURE OF INTERVIEWER _____</p>		<p>82. SIGNATURE OF INTERVIEWER _____</p>	
<p>83. SIGNATURE OF INTERVIEWER _____</p>		<p>84. SIGNATURE OF INTERVIEWER _____</p>	
<p>85. SIGNATURE OF INTERVIEWER _____</p>		<p>86. SIGNATURE OF INTERVIEWER _____</p>	
<p>87. SIGNATURE OF INTERVIEWER _____</p>		<p>88. SIGNATURE OF INTERVIEWER _____</p>	
<p>89. SIGNATURE OF INTERVIEWER _____</p>		<p>90. SIGNATURE OF INTERVIEWER _____</p>	
<p>91. SIGNATURE OF INTERVIEWER _____</p>		<p>92. SIGNATURE OF INTERVIEWER _____</p>	
<p>93. SIGNATURE OF INTERVIEWER _____</p>		<p>94. SIGNATURE OF INTERVIEWER _____</p>	
<p>95. SIGNATURE OF INTERVIEWER _____</p>		<p>96. SIGNATURE OF INTERVIEWER _____</p>	
<p>97. SIGNATURE OF INTERVIEWER _____</p>		<p>98. SIGNATURE OF INTERVIEWER _____</p>	
<p>99. SIGNATURE OF INTERVIEWER _____</p>		<p>100. SIGNATURE OF INTERVIEWER _____</p>	

CERTIFICATE OF DEATH

13627

13605

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Owings Mills 5 yrs. c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rosewood State Training School				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 3012 Seamon Ave.			
3. NAME OF DECEASED (Type or print) Michael (Nicker) Mills				4. DATE OF DEATH Month 12 Day 11 Year 19 61			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/10/44	
9. AGE (In years last birthday) 17 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) dependent		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George Mills		14. MOTHER'S MAIDEN NAME Virginia Rose		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. ---		17. INFORMANT Rosewood Records, Owings Mills, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LOBAR PNEUMONIA DUE TO (b) (Many hemolytic streptococci present; Group A) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Birth injury with Quadriplegia and Epilepsy							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (H) (this hospital) attended the deceased from 10/1 , 19 56 to 12/11 , 19 61 that (H) (we) last saw the deceased alive on 12/11 , 19 61 and that death occurred 11:20 p.m. the causes and on the date stated above.							
22a. SIGNATURE Harry G. Butler				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 12/12/61	
22c. PHYSICIAN'S NAME (Type) Harry G. Butler, M.D.				22d. ADDRESS Rosewood Lane, Owings Mills, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12-15-61		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn		23d. LOCATION (City, town or county) (State) BALTIMORE, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Marshall W. Jones				ADDRESS 1735		25a. REC'D BY REGISTRAR DATE DEC 18 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Haines			

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

100-5

100-5

(M)

(1)

Investigation with photographs and film

Shirley K. Carter

March 10, 1964

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13628

13606

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cockeysville</i>				c. LENGTH OF STAY IN 1b <i>56 years</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Shenwood Road</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Theophilus Orlando Minnich</i>				4. DATE OF DEATH <i>December 25 1961</i>			
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>8 April 1883</i>	
9. AGE (In years last birthday) <i>78</i> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Stonecutter</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Monuments</i>		11. BIRTHPLACE (State or foreign country) <i>Cockeysville, Balt Co.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>							
13. FATHER'S NAME <i>John Minnich</i>				14. MOTHER'S MAIDEN NAME <i>Martha Uhler</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>				16. SOCIAL SECURITY NO. <i>215-05-8156</i>		17. INFORMANT <i>wife - Mary A.</i> Address <i>Same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac failure</i> 422.1 DUE TO <i>Arteriosclerotic Cardiovascular disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>same</i> DUE TO (c) <i>years</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Pneumococcosis</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <i>Dec 1961</i> to <i>Dec 1961</i> , that (I) (we) last saw the deceased alive on <i>Dec 25 1961</i> , and that death occurred on <i>Dec 25 1961</i> at <i>6 A. M.</i> from the causes and on the date stated above.							
22a. SIGNATURE <i>Walter T. Kees</i>				22b. DATE SIGNED <i>25 December 1961</i>			
22c. PHYSICIAN'S NAME (Type) <i>Walter T. Kees</i>				22d. ADDRESS <i>Cockeysville, Maryland</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12-28-61</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Poplar Grove</i>		23d. LOCATION (City, town, or county) (State) <i>Cockeysville, Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Brooks Funeral Service, Towson 4, Md.</i>				25a. REC'D BY REGISTRAR <i>DEC 27 '61</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur E. Kimes</i>	

MEDICAL CERTIFICATION

12000

CENTRAL DE DEATH

12000

415-02-8150

12000

12000

12000

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH e. COUNTY Baltimore MARYLAND												2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Md. b. COUNTY Baltimore											
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson												c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Towson Convalescent Home												d. STREET ADDRESS 215 Goodale Road											
3. NAME OF DECEASED (Type or print) Marie G. Mohlenrich												4. DATE OF DEATH Dec. 1 19 61											
5. SEX F												6. COLOR OR RACE W											
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>												8. DATE OF BIRTH June 23, 1870											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife												11. BIRTHPLACE (County & State, or foreign country) Baltimore Md.											
13. FATHER'S NAME Theodore Griesman												14. MOTHER'S MAIDEN NAME Kuniganda Kröll											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) I												16. SOCIAL SECURITY NO. Mrs. T. Russell Hicks Above											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Decompensative Cardio Vascular Disease DUE TO (b) 2 yrs. Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19												20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)												20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from Nov-25-1961 to Dec-1-1961 , that (I) (we) last saw the deceased alive on Dec-1-1961 , and that death occurred 7:30p from the causes and on the date stated above.												22a. SIGNATURE Laurence C. Post M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>											
22b. DATE SIGNED 12/2/61												22c. ADDRESS 6805 York Rd - Baltimore Md											
22d. PHYSICIAN'S NAME (Type) LAURENCE C. Post												23a. BURIAL, CREMATION, REMOVAL (Specify) Burial											
23b. DATE THEREOF 12-4-61												23c. NAME OF CEMETERY OR CREMATORY Baltimore											
23d. LOCATION (City, town or county) Baltimore												23e. REC'D BY REGISTRAR DEC 5 '61											
24. FUNERAL DIRECTOR'S SIGNATURE H.W. Jenkins & Sons Co. 4905 York Rd. Balto												25b. REGISTRAR'S SIGNATURE Conroy S. Thomas											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the deceased was not in a hospital or attending physician. TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
13630
CERTIFICATE OF DEATH
13608

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 8 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Abington, Maryland d. STREET ADDRESS R. D. #1 - Box 422	
3. NAME OF DECEASED (Type or print) First Frank Middle Keithley Last Moore		4. DATE OF DEATH Month December Day 12 Year 19 61	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 7, 1879
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 12 Days 12 Hours 12 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY Agriculture	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME unknown ELIJAH J. B. MOORE		14. MOTHER'S MAIDEN NAME unknown LAURA KEITHLEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Dec. 4, 1961 to Dec. 12, 1961 , that (I) (we) last saw the deceased alive on Dec. 12, 1961 , and that death occurred at 11:20 P. M. from the causes and on the date stated above.			
22a. SIGNATURE Stella Wachslar		22b. DATE SIGNED 12-12-61	
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 15, 1961	
23c. NAME OF CEMETERY OR CREMATORY Union Chapel Meth. Cem.		23d. LOCATION (City, town, or county) (State) Joppa, Harford Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph W. Foster		25a. REC'D BY REGISTRAR DATE DEC 15 '61	
ADDRESS 42 Broadway + Williams St. Bel Air, Maryland		25b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13631

13609

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X Parkville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>7602 Park Drive</u>		d. STREET ADDRESS <u>1 7602 Park Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>C.</u> Last <u>Morgereth</u>		4. DATE OF DEATH Month <u>12</u> Day <u>2</u> Year <u>19 61</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) <u>Oct 3 1898 63</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shipping Clerk</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>HENRY MORGERETH</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH BEUMLER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>314-03-2552</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>153.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma Liver Met.</u> <u>Carcinoma Sigmoid.</u> <u>Arterioscl. Cord. Vasc. Dis.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cachexia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Cachexia</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 5 1957</u> to <u>Dec 2 1961</u> , that (I) (we) last saw the deceased alive on <u>Dec 2 1961</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. SIGNATURE <u>Frank T. Kasik Jr.</u>		22b. ADDRESS <u>9005 Harford Rd. Balto Md.</u>	
22c. PHYSICIAN'S NAME (Type) <u>FRANK T. KASIK JR.</u>		22d. ADDRESS <u>9005 Harford Rd. Balto Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>12-6-61</u>		23b. DATE THEREOF <u>12-6-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cem</u>		23d. LOCATION (City, town or county) (State) <u>BALTO MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leland J. Hook</u>		25a. REC'D BY REGISTRAR <u>DEC 5 '61</u>	
ADDRESS <u>5305 Harford</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13632

CERTIFICATE OF DEATH

Reg. Dist. No. 12610

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY <input checked="" type="checkbox"/>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 3V01-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Register Ave & Sherwood Rd Armcast Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last AUGUSTA S. MULLIN				4. DATE OF DEATH Month Day Year 12/12/61 19			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1914	
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Reg. Nurse				10b. KIND OF BUSINESS OR INDUSTRY Union Mem. Hospt.			
11. BIRTHPLACE (State or foreign country) Harford Co.				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME John P. Webster, Sr.				14. MOTHER'S MAIDEN NAME Mary C. Wright			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. -			
17. INFORMANT Address Miss. Kathleen Scriven-415 Homeland Ave.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thalamic Tumor 223X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 11-1 , 19 60 , to 12-12 , 19 61 , that I last saw the deceased alive on 12-12 , 19 61 , and that death occurred at 10:15 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1101 St Paul St Balto Md DATE SIGNED 12-14-61 ACTUAL SIGNATURE Alfred G. Ossman Jr M.D. PHYSICIAN'S NAME (Type) Alfred G. Ossman Jr M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/16/61		22c. NAME OF CEMETERY OR CREMATORY Cathedral Cem.		22d. LOCATION (City, town, or county) (State) Balto. City	
23. FUNERAL DIRECTOR'S SIGNATURE Wiedefeld & Son WIEDEFELD & SON GREENMOUNT AVE & 22ND				24a. REC'D BY REGISTRAR DEC 19 '61		24b. REGISTRAR'S SIGNATURE Charles E. Hennes	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13633

13611

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 169 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS 7928 Gilmore Ave.	
3. NAME OF DECEASED (Type or print) MARTIN C. MURRAY, Sr.		4. DATE OF DEATH Month December Day 30 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/13/87
9. AGE (In years last birthday) yrs. 74		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Metal Worker		10b. KIND OF BUSINESS OR INDUSTRY Roofing Industry	
11. BIRTHPLACE (County & State, or foreign country) Philadelphia, Penna		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles J. Murray		14. MOTHER'S MAIDEN NAME Catherine Hannigan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war dates of service) WW-1		16. SOCIAL SECURITY NO. 219-03-0929	
17. INFORMANT Clinical Records		Address VA Hospital Baltimore 18, Maryland-FORT HOWARD DIVISION	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SQUAMOUS CELL CARCINOMA, LEFT UPPER LOBE BRONCHUS 191.9 DUE TO WITH LOCAL METASTASES Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Arteriosclerosis, general		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 11, 1961 to Dec. 30, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Dec. 30, 1961 , and that death occurred at 11:15 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Paul Bormel, M.D.		22b. DATE SIGNED 12/30/61	
22c. PHYSICIAN'S NAME (Type) PAUL BORMEL, M.D.		22d. ADDRESS VAH Balto 18, Md. Fort Howard Division	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-4-62	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCATION (City, town or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Cvach Funeral Home		25a. REC'D BY REGISTRAR 1211 Chesaco Ave. Baltimore, Maryland	
25b. REGISTRAR'S SIGNATURE DATE JAN 3 '62		25c. REGISTRAR'S SIGNATURE Carroll S. House	

1881

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1881

CERTIFICATE OF DEATH

Reg. Dist. No. 13612

13634

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CARNEY</u>				c. LENGTH OF STAY IN 1b <u>49 YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>FRANCIS</u> Middle <u>G</u> Last <u>MYERS</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>16</u> Year <u>1961</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 5-1886</u>		9. AGE (In years lost birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Builder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Homes</u>		11. BIRTHPLACE (State or foreign country) <u>PENN.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>BENJAMIN F. MYERS</u>				14. MOTHER'S MAIDEN NAME <u>EDITH FIFER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-05-0001</u>		INFORMANT <u>MARGARET M MYERS</u> Address <u>SAME</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Acute Coronary Occlusion.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Atherosclerosis</u> (c) <u>Sudden</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs +</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Dec 7, 1958</u> to <u>Dec 16, 1961</u> , that I last saw the deceased alive on <u>Dec 7, 1961</u> , and that death occurred at <u>11:58 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frank T. Kasik</u> M.D.				ADDRESS (Street, city or town, state) <u>9005 HARFORD Rd</u> DATE SIGNED <u>12/18/61</u>			
PHYSICIAN'S NAME (Type) <u>FRANK T KASIK</u>				<u>BALTIMORE 14 MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/20/1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WARKWOOD</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. F. EVANS & SON</u> ADDRESS <u>8802 HARFORD Rd</u>				24a. REC'D BY REGISTRAR <u>DEC 20 '61</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Cynthia S. Kasik</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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Chapel

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CERTIFICATE OF DEATH

13613

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore Catonsville</u>		c. LENGTH OF STAY IN 1b <u>8 months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Fred</u> Middle <u>Joseph</u> Last <u>Myers</u>		4. DATE OF DEATH Month <u>December</u> Day <u>18</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-3-84</u>
9. AGE (In years last birthday) <u>77</u> yrs.		10. UNDER 1 YEAR Months <u>12</u> Days <u>X</u>	11. UNDER 24 HRS. Hours <u>2</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fisherman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Charles Myers</u>		14. MOTHER'S MAIDEN NAME <u>Victoria Sachen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>214-22-1878</u>	
17. INFORMANT <u>Lee Myers</u>		Address <u>66 Green St. Aberdeen, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO <u>450.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of the prostate</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 9</u> <u>1936</u> to <u>Dec. 18</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>Dec. 18</u> <u>1961</u> , and that death occurred at <u>6:25</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Stella Wachsler</u> M.D.		22b. DATE SIGNED <u>12-18-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stella Wachsler, M. D.</u>		22d. ADDRESS <u>SPRING GROVE STATE HOSPITAL</u> <u>Catonsville 28, Maryland</u>	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/20/1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Bakers Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Aberdeen, Harford Co. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Tarring</u>		25. REC'D BY REGISTRAR DATE <u>DEC 26 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

STATE OF NEW YORK

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RECEIVED THE DEPARTMENT OF HEALTH

HOSPITALS AND CLINICS - NEW YORK

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. **13614**

13636

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk (22)				c. LENGTH OF STAY IN 1b 39 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 17 Woodland Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ANNA Middle ++++ Last NAROWANSKI				4. DATE OF DEATH Month December Day 25th Year 19 61			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 16th, 1893	
9. AGE (In years last birthday) yrs. 68		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Russia	
12. CITIZEN OF WHAT COUNTRY? U.S.S.R.							
13. FATHER'S NAME ??? Seredich				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 220-09-57924		17. INFORMANT Feodor Narowanski Address same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial A.V. Disease 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from 19 56 to Dec 25, 1961 , that I last saw the deceased alive on Dec 5, 19 61 , and that death occurred at 11:15 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6714 Holabird Avenue DATE SIGNED 12/26/61 ACTUAL SIGNATURE Stephen C. Mackowiak M.D. 6714 Holabird Avenue DATE SIGNED 12/26/61 PHYSICIAN'S NAME (Type) Stephen C. Mackowiak, M.D. Baltimore 22, Maryland 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 12/29/61 22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland 23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Inc., Dundalk 22, Md 24a. REC'D BY REGISTRAR DEC 28 '61 24b. REGISTRAR'S SIGNATURE Arthur L. Kraus							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

6232

<p>1. NAME OF DECEASED [REDACTED]</p>		<p>2. SEX [REDACTED]</p>		<p>3. AGE [REDACTED]</p>	
<p>4. DATE OF BIRTH [REDACTED]</p>		<p>5. PLACE OF BIRTH [REDACTED]</p>		<p>6. OCCUPATION [REDACTED]</p>	
<p>7. MARITAL STATUS [REDACTED]</p>		<p>8. CAUSE OF DEATH [REDACTED]</p>		<p>9. MEDICAL HISTORY [REDACTED]</p>	
<p>10. DATE OF DEATH [REDACTED]</p>		<p>11. PLACE OF DEATH [REDACTED]</p>		<p>12. SIGNATURE OF DECEASED [REDACTED]</p>	
<p>13. SIGNATURE OF WITNESS [REDACTED]</p>		<p>14. SIGNATURE OF PHYSICIAN [REDACTED]</p>		<p>15. SIGNATURE OF REGISTRAR [REDACTED]</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13637				Item 4 Film G302 12/13/61 iwk				13615			
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 119 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) CLARENCE A. NASH				4. DATE OF DEATH Month December Day 16 Year 1961							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 9, 1892		9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter				10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (County & State, or foreign country) Trenton, Maryland			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME George A. Nash				14. MOTHER'S MAIDEN NAME Mattie G. Gill							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WW I 215-01-0370		17. INFORMANT Address Clinical Records, VAH, Baltimore 18, Maryland Fort Howard Division					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF LUNGS WITH METASTASES 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____										INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Urinary tract infection. Bronchopneumonia											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from August 8, 1961 to December 5, 1961 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on December 5, 1961 , and that death occurred at 11:00 P. M., from the causes and on the date stated above.											
22a. SIGNATURE Irving Freeman				M.D. IRVING FREEMAN, M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE 12/6/61			
22c. PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D.				22d. ADDRESS VAH, BALTIMORE 18, MD., FT. HOWARD DIVISION							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-9-1961		23c. NAME OF CEMETERY OR CREMATORY Grace Methodist Church			23d. LOCATION (City, town or county) (State) Baltimore County, Maryland				
24 FUNERAL DIRECTOR'S SIGNATURE Edward C. Tipton				ADDRESS Hampstead, Maryland				25a. REC'D BY REGISTRAR DATE DEC 11 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraw	

VR A15 (4)
15M 9/60

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13638

13616

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 3 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 2447 McCulloh Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM L NASH		4. DATE OF DEATH Month Day Year December 16 1961	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 9, 1914
9. AGE (In years last birthday) 47 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. BIRTHPLACE (County & State, or foreign country) Catawba, South Carolina
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Nash		14. MOTHER'S MAIDEN NAME Sadie Jordan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 197-03-6208	
17. INFORMANT Clinical Records, VAH Ft Howard Division		18. ADDRESS Baltimore 18, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabets Mellitus; Laennec's Cirrhosis; Delerium Tremens		INTERVAL BETWEEN ONSET AND DEATH 6 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 13 1961 to December 16 1961 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on December 16 1961 , and that death occurred at 9:15A , from the causes and on the date stated above.			
22a. SIGNATURE John D. Talbert, M.D.		22b. DATE 12/16/61	
22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, Acting Chief, Medical Service VAH Balto 18, Md., Ft Howard Div		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-21-61	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Elroy O. Wilson		25a. REC'D BY REGISTRAR DEC 29 '61	
ADDRESS 1000 Brantley Ave Balto 17, Md		25b. REGISTRAR'S SIGNATURE Arthur L. House	

13810

13810

CERTIFICATE OF DEATH

1938

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NAME OF DECEASED

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

EDUCATION

OCCUPATION

RELIGION

TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13640

13618

1. PLACE OF DEATH - a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN 1b 7mths16dys d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1144 West Lombard Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary Edna Nickles First Middle Last or/		4. DATE OF DEATH Month Day Year December 20 1961	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1884 Sept. 10, 1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
13. FATHER'S NAME Samuel Clark		14. MOTHER'S MAIDEN NAME Mary Sullivan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown no		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Multiple decubital gangrene DUE TO (c) Advanced senile brain disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from May 4 19 61 to Dec. 20 19 61 , that (I) (we) last saw the deceased alive on Dec. 20 19 61 , and that death occurred at 7:40 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Stella Wachslar		22b. DATE SIGNED 12-20-61	
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M. D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/23/61	
23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION (City, town, or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		25a. REC'D BY REGISTRAR DEC 22 '61	
ADDRESS 4107 Wilkens Ave.		25b. REGISTRAR'S SIGNATURE Arthur L. Kline	

VR A15 (4)
15M 9/59

CERTIFICATE OF DEATH

1940

1940

CHILDREN

Richard H. Richard 410 Wilkins Ave.

Richard H. Richard 410 Wilkins Ave.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. Page 1 and 2 should be completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13641

13619

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe c. LENGTH OF STAY IN b 3 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1259 Elm Rd.				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Balt. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe Md. d. STREET ADDRESS 1259 Elm Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Alice O'Connor				4. DATE OF DEATH Dec 20, 1961			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 30, 1890	
9. AGE (In years last birthday) 71 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (County & State, or foreign country) Baltimore Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Bennet Ward		14. MOTHER'S MAIDEN NAME Matilda Krickhaun			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 212-22-7257		17. INFORMANT Mary Deitrick 1259 Elm Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 180X General Carcinomatosis Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Papillary Carcinoma of Kidney (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 3 months 3 years				INTERVAL BETWEEN ONSET AND DEATH 3 months 3 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/16 to 12/20 , 19 61 , that (I) (we) last saw the deceased alive on 12/21 , 19 61 , and that death occurred at 9:30 P , from the causes and on the date stated above.							
22a. SIGNATURE Eliot W. Johnson M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/27/61	
22c. PHYSICIAN'S NAME (Type) Dr. E.W. Johnson				22d. ADDRESS 3432 Frederick Ave.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec 23, 1961		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		23d. LOCATION (City, town or county) (State) Baltimore Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Ambrose Inc				ADDRESS 1328 Sulphur Spring Rd Baltimore 27, Md.		25a. REC'D BY REGISTRAR DEC 27 '61	
				25b. REGISTRAR'S SIGNATURE William S. Kenna			

18619

CERTIFICATE OF MARRIAGE

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TO HOSPITAL OR AT HOME: The low requires that the death certificate be executed within 24 hours after death. If the death occurs in a hospital or attending physician, the low requires that the death certificate be executed within 24 hours after death. If the death occurs in a hospital or attending physician, the low requires that the death certificate be executed within 24 hours after death. If the death occurs in a hospital or attending physician, the low requires that the death certificate be executed within 24 hours after death.

DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY BALTO.		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.) CATONSVILLE		c. LENGTH OF STAY IN 1b FOREST HAVEN		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD		b. COUNTY BALTO	
3. NAME OF DECEASED (Type or print) George C. Pattie		4. DATE OF DEATH Month Dec Day 26 Year 1961		5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 1886		9. AGE (In years last birthday) 75		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PHARMACIST		10b. KIND OF BUSINESS OR INDUSTRY Drug		11. BIRTHPLACE (State or foreign country) VA.	
12. CITIZEN OF WHAT COUNTRY? U.S		13. FATHER'S NAME Caldwell		14. MOTHER'S MAIDEN NAME Pattie		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —	
17. INFORMANT Mr. Clyde W. Marlow		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIO SCLEROTIC DISEASE - UNIPOLAR DUE TO (c) DISSOLVE		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) 12/26/61		20g. (County) 12/27/61		20h. (State) 12/27/61		21. I certify that (I) (this hospital) attended the deceased from 11/1/59 to 12/26/61 , that (I) (we) last saw the deceased alive on 1/26/61 , and that death occurred at 8 PM , from the causes and on the date stated above.		22a. SIGNATURE John H. Shaw	
22b. DATE SIGNED 12/27/61		22c. PHYSICIAN'S NAME (Type) JOHN H. SHAW M.D.		22d. ADDRESS 5500 EDMONDSON AVE. BOX-28, MD		23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE THEREOF Dec-29, 1961	
23c. NAME OF CEMETERY OR CREMATORY WARRENTON CEMETERY		23d. LOCATION (City, town, or county) WARRENTON		23e. (State) VA		24. FUNERAL DIRECTOR'S SIGNATURE Moser Funeral Home		25. REC'D BY REGISTRAR DEC 28 '61	
25a. REGISTRAR'S SIGNATURE C. S. MacNabb		25b. REGISTRAR'S SIGNATURE Arthur L. Hanna		25c. REGISTRAR'S SIGNATURE Arthur L. Hanna		25d. REGISTRAR'S SIGNATURE Arthur L. Hanna		25e. REGISTRAR'S SIGNATURE Arthur L. Hanna	

C. S. MacNabb.

CERTIFICATE OF DEATH

1912

Full Name of Deceased
Date of Birth
Date of Death
Place of Birth
Place of Death
Cause of Death
Signature of Registrar
Signature of Medical Officer
Signature of Coroner

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13643

13621

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Cockeyville</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Cockeyville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeyville</u>	
c. LENGTH OF STAY IN lb <u>Life</u>		d. STREET ADDRESS <u>1 Sherwood Road</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Maggie</u> First <u>M</u> Middle <u>Pearce</u> Last		4. DATE OF DEATH <u>December 1</u> 19 <u>61</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-11-1877</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>XXXXXXXXXXXXX Caleb Monroe</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Ann Gill</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Miss Durcas A. Pierce</u> Address <u>Cockeyville Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <u>Arteriosclerotic cardiovascular disease.</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the <u>under-</u> lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 12 1961</u> to <u>Dec 1</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Nov 28</u> 19 <u>61</u> , and that death occurred at <u>5:30</u> P.M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Elizabeth B. Sherrill</u> M.D.		22b. DATE SIGNED <u>12/1/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Elizabeth B. Sherrill M.D.</u>		22d. ADDRESS <u>Cockeyville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12-4-1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Jessop Meth Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Sparks Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Brooks Funeral Service</u> ADDRESS <u>Towson 4, Md</u>		25a. REC'D BY REGISTRAR <u>DEC 4 '61</u> DATE 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

Page 4
The law requires that the death certificate be executed within 24 hours after death.
TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after death.
TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



1943

CERTIFICATE OF TITLE

1943

W. H. L. L. L.

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Reg. Dis. No. 18622

MEDICAL CERTIFICATION

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13645

13623

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Quinn's Mills</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Quinn's Mills</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>25 Featherbed Lane</u>				d. STREET ADDRESS <u>25 Featherbed Lane</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>PRESTON HARRY Phillips</u>				4. DATE OF DEATH Month Day Year <u>December 16 1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 7, 1909</u>		9. AGE (In years lost birthday) <u>52</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore Transit</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George W. Phillips</u>				14. MOTHER'S MAIDEN NAME <u>Anna Tapman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Max Preston Phillips</u>		Address <u>Quinn's Mills, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma - pancreas with metastasis</u> 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH <u>7 months</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 1961</u> to <u>December 16, 1961</u> , that (I) (we) last saw the deceased alive on <u>December 16, 1961</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Charles E. McWilliams</u>				22b. DATE <u>December 16, 1961</u>		22c. PHYSICIAN'S NAME (Type) <u>Charles E. McWilliams</u>	
M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22d. ADDRESS <u>11904 Kenton Rd. Kenton, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		23b. DATE THEREOF <u>12-19-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Grand Ridge</u>		23d. LOCATION (City, town, or county) (State) <u>Pikesville Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell</u>				24a. REC'D BY REGISTRAR <u>DEC 20 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. The law requires that the death certificate be executed within 24 hours after the death.

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

1901

(M)

CHIEF CLERK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH BALTIMORE COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 3rd-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital				d. STREET ADDRESS 1912 WILHELM STREET			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last JEROME CHARLES POIST-S.				4. DATE OF DEATH Month Day Year 12-10-1961			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-17-11	9. AGE (In years last birthday) 50 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during last working life, even if retired) DYE SETTER		10b. KIND OF BUSINESS OR INDUSTRY DYE SETTING		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAMUEL POIST				14. MOTHER'S MAIDEN NAME CATHERINE SCHLIMMIS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 705-10-9692		17. INFORMANT Address Hospital Records, Mt. Wilson State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FAR ADVANCED PULMONARY TUBERCULOSIS 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH 7 years.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 10-5-1955 to 12-10-1961, that (I) (we) last saw the deceased alive on 12-10-1961, and that death occurred at 11:45 P.M. from the causes and on the date stated above.					
22a. SIGNATURE W. Newcomer				22b. DATE SIGNED 12-11-61		22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent	
22d. ADDRESS Mt. Wilson State Hospital, Mt. Wilson, Md.				23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
23b. DATE THEREOF 12/13/61		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemty.		23d. LOCATION (City, town, or county) (State) Balto. Md.			
24. FUNERAL DIRECTOR'S SIGNATURE W. J. Gabe				25a. REC'D BY REGISTRAR DATE DEC 13 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kneass	

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13647

13624

100-443887-1000

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. FUNDAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13646

Item 4 Film G305 1/11/62 iwk

13625

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rosewood State Training School</u>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>3V01-4</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>430 East 22nd Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Andre</u> <u>Matthew</u> <u>Powell</u> First Middle Last			4. DATE OF DEATH Month <u>12</u> Day <u>24</u> Year <u>1961</u>		
5. SEX <u>MALE</u>			6. COLOR OR RACE <u>NEGRO</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>12-16-57</u>		
9. AGE (In years last birthday) <u>4</u> yrs.			IF UNDER 1 YEAR Months <u>4</u> Days <u>12</u> Hours <u>24</u> Min. <u>19</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>James Matthew Powell</u>			14. MOTHER'S MAIDEN NAME <u>Gwendolyn Powell Marshall</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(if yes give year or dates of service)</u>			16. SOCIAL SECURITY NO. <u>INFORMANT</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonitis of left lower lobe with</u> DUE TO (b) <u>advanced dehydration</u> DUE TO (c) <u>gargoylism</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>o.m.</u> <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/24</u> to <u>12/24</u> 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>12/24</u> 19 <u>61</u> and that death occurred at <u>11:10 AM</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>Harry S. Butler</u> M.D.			22b. DATE SIGNED <u>DEC 27 '61</u>		
22c. PHYSICIAN'S NAME (Type) <u>Rosewood Training School</u>			22d. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-29-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn</u>	
23d. LOCATION (City, town or county) <u>Westport Md</u>		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <u>A. Halstead</u>			25a. REC'D BY REGISTRAR <u>DEC 27 '61</u>		
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoma</u>					

1885

1885

[Faint, mostly illegible handwritten text, possibly a letter or report.]

[Faint handwritten signature or name, possibly "P. ..."]

[Faint handwritten signature or name, possibly "C. ..."]

Received of
the Treasurer

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1885

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13649

CERTIFICATE OF DEATH

13626

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurstleigh				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurstleigh			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7108 Bellona Avenue				d. STREET ADDRESS 7108 Bellona Ave.			
3. NAME OF DECEASED (Type or print) May Frances McCarthy Pritchard				4. DATE OF DEATH Month December Day 30 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 8, 1880	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Queen Town, Ireland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Michael J. McCarthy				14. MOTHER'S MAIDEN NAME Ellen Dunn			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) None (If yes give year or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Jack F. Pritchard Address 7001 Copleigh Road 12	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary atherosclerosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 12 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from October 3, 1961 to December 3, 1961 , that (I) (we) last saw the deceased alive on December 3, 1961 , and that death occurred at 11:30 A.M. from the causes and on the date stated above.							
22a. SIGNATURE A. Allan Spier				M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/2/62	
22c. PHYSICIAN'S NAME (Type) A. ALLAN SPIER				22d. ADDRESS 1501 Parkridge Rd			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/2/62		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d. LOCATION (City, town or county) (State) Pikesville, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE William J. Trickett				25a. REC'D BY REGISTRAR Arthur S. Thomas		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	
DATE JAN 3 '62							

VR A15 (4)
15M 9/60

13333

13333



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
13648					13627									
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 54 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 1704 Brady Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) ALBERT			First Middle Last ----- PRITCHETT		4. DATE OF DEATH December 18 1961		Month Day Year							
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 27, 1896		9. AGE (In years last birthday) 64 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer-Retired		10b. KIND OF BUSINESS OR INDUSTRY Chemical Plant		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.						
13. FATHER'S NAME Albert Pritchett					14. MOTHER'S MAIDEN NAME Maggie Pritchett									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes					16. SOCIAL SECURITY NO. WW I					17. INFORMATION Clinical Records, VAH, Baltimore 18, Maryland Fort Howard Division				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA DUE TO (b) NEPHROSCLEROSIS (c) ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Cardiovascular disease. Pyelonephritis. Uremic Encephalitis. Benign Prostatic Hypertrophy.								INTERVAL BETWEEN ONSET AND DEATH 4 MONTHS		UNKNOWN		UNKNOWN		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Oct. 25, 1961 to Dec. 18, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Dec. 18, 1961 , and that death occurred at 4:30 P.M. from the causes and on the date stated above.														
22a. SIGNATURE Irving Freeman					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> M.D. 22d. ADDRESS BALTIMORE 18, MD. VAH, Fort Howard Div.					22b. DATE SIGNED 12/19/61				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE OF 12/23/61		23c. NAME OF CEMETERY OR CREMATORY Mount Calvary Cemetery		23d. LOCATION (City, town or county) Baltimore; Maryland							
24. FUNERAL DIRECTOR'S SIGNATURE Robert E. Williams					ADDRESS 1701 N. Bond St., Balto., Md.					25a. REC'D BY REGISTRAR DATE DEC 28 '61				
										25b. REGISTRAR'S SIGNATURE Robert E. Williams				

Robert E. Williams, 1701 N. Bond St., Detroit, Mich.

12/13/51 Home Delivery Dept.

1701 Bond St., Detroit, Mich. 48201

Dec. 10

Dec. 10

Report of Cardiac Catheterization, 12/10/51

ANTHONY J. JONES

HEALTHCARE CENTER

UNION

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1701 Bond St., Detroit, Mich. 48201

1701 Bond St.

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
13650													
13628													
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonoville</u> c. LENGTH OF STAY IN 1b <u>25 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) _____						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X Catonoville</u> d. STREET ADDRESS <u>115 Holmhurst Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>GERTRUDE MAINZ PROFFEN</u>						4. DATE OF DEATH Month Day Year <u>DEC. 24 1961</u>							
5. SEX <u>F</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 5, 1894</u>		9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>					
13. FATHER'S NAME <u>JOHN MAINZ</u>						14. MOTHER'S MAIDEN NAME <u>MARY ?</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. _____		17. INFORMANT <u>Ernest Proffen</u>		Address <u>115 Holmhurst Ave</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion - acute</u> <u>420.1</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) _____												INTERVAL BETWEEN ONSET AND DEATH <u>Several minutes</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that (I) (this hospital) attended the deceased from <u>January 25, 1960</u> to <u>present</u> , 19____, that (I) (we) last saw the deceased alive on <u>8/18</u> , 19 <u>61</u> , and that death occurred <u>19:10h</u> , from the causes and on the date stated above.													
22a. SIGNATURE <u>John M. Gerwig Jr.</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>12-24-61</u>					
22c. PHYSICIAN'S NAME (Type) <u>JOHN M. GERWIG JR.</u>						22d. ADDRESS <u>400 Grolland Rd, Balto 28 Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/28/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		23d. LOCATION (City, town or county) <u>Balto. Md.</u> (State) _____							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Terrance Hoff + Sons</u> ADDRESS <u>(28)</u>						25a. REC'D BY REGISTRAR <u>DEC 29 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>					

(M)

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G304 1/2/62 iwk

CERTIFICATE OF DEATH

Reg. Dist. No. 13629

13651

1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY BALTO.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OWING MILLS,			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HOUSE IN PINES				e. STREET ADDRESS 27 Pleasant Hill Road IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELIZABETH Middle L. Last PURDUM				4. DATE OF DEATH Month DEC. Day 24 Year 1961			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 2, 1876		9. AGE (In years lost birthday) 85 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) REG. NURSE RET.		10b. KIND OF BUSINESS OR INDUSTRY HOSPITAL		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME PATRICK DORAN				14. MOTHER'S MAIDEN NAME ROSA. BYRNE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) C		16. SOCIAL SECURITY NO. C		INFORMANT C		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Myocarditis - chronic decompensated DUE TO (b) Hypertension DUE TO (c) Atherosclerotic disease - general CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.							INTERVAL BETWEEN ONSET AND DEATH 3 1/2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-1-1940 to 12-24-61 , that I last saw the deceased alive on 12-24-1961 and that death occurred at 5:30 M., from the causes and on the date stated above.							
ACTUAL SIGNATURE James G. Saffell				DATE SIGNED 12-24-61			
PHYSICIAN'S NAME (Type) JAMES G. SAFFELL				ADDRESS (Street, city or town, state) REISTERTOWN, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-28-61		22c. NAME OF CEMETERY OR CREMATORY Greenwood Cem.		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Farley - Carbaugh Funeral Home, Catonsville, Md.				24a. REC'D BY REGISTRAR DATE DEC 28 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It is to be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13652
CERTIFICATE OF DEATH
13630

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> <u>Baltimore</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS <u>404 W. Pennsylvania Avenue</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>404 W. Pennsylvania Avenue</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>M.</u> Last <u>Ray</u>				4. DATE OF DEATH Month <u>12</u> Day <u>7</u> Year <u>61</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-11-1879</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Robert Paul</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Sweeley</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Mr. C. T. Ray-Phoenix, Maryland</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic cardiovascular disease</u> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April, 1958</u> to <u>December 7, 1961</u> , that (I) (we) last saw the deceased alive on <u>December 7, 1961</u> , and that death occurred at <u>11:45 P</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>A. Allan Spier</u>				22b. DATE SIGNED <u>12/8/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>A. ALLAN SPIER</u>				22d. ADDRESS <u>1501 Pentridge Rd. Baltimore Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>12-9-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Alto Reste Park</u>		23d. LOCATION (City, town or county) (State) <u>Altonna, Pennsylvania</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Suckera Sons</u>				ADDRESS <u>Subs. 17, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 8 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

13030

13030



13030

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. **13631**

13653

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 6Months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANNA Middle W. Last REBMAN		4. DATE OF DEATH Month DECEMBER Day 16 Year 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 4, 1870
9. AGE (In years last birthday) 91 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	
11. BIRTHPLACE (State or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY LUCKER		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 217 14 1971	
17. INFORMANT Mrs Elsie Grimm		Address 8. N. Rolling Road (280	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Frac. hip - recent (6 Oct 1961)		INTERVAL BETWEEN ONSET AND DEATH 10 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, or item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1951 to 16 Dec , 1961, that I last saw the deceased alive on 16 Dec , 1961, and that death occurred at 12:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE M. Theodore Boss		DATE SIGNED 12/18/61	
PHYSICIAN'S NAME (Type) Theodore Boss M.D.		ADDRESS (Street, city or town, state) 817 Medical Arts Building	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF DEC. 19, 1961	
22c. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEMETERY		22d. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS INC. BALTIMORE MD.		24a. REC'D BY REGISTRAR DATE DEC 20 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

Page 4
The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

100-100000

CERTIFICATE OF DEATH

17553



NAME OF DECEASED: [illegible]
AGE: [illegible] SEX: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
OCCUPATION: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
DATE OF DEATH: [illegible]
SIGNATURE OF REGISTRAR: [illegible]
OFFICE: [illegible]

DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF REGISTRAR: [illegible]
OFFICE: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF REGISTRAR: [illegible]
OFFICE: [illegible]

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13654

CERTIFICATE OF DEATH

13632

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 6400 Bellona Ave c. LENGTH OF STAY IN 1b 2 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Mercy Villa		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 3401-4 d. STREET ADDRESS 3420 Erdman Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Gertrude Agatha Riordan		4. DATE OF DEATH Month 12 - Day 17 Year 1961	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-4-1886
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 12 Days 17 Hours 1961	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Legal Stenographer		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael Riordan		14. MOTHER'S MAIDEN NAME Mary Courtney	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-01-0203	
17. INFORMANT Mrs. Wm. J. Daniel		Address 169 Oakleigh Village	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardio vascular disease DUE TO (b) 422-1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-15- 1958 to 12-17- 1961 that (I) (you) saw the deceased alive on 12-16- 1961 and that death occurred at 3P.M. from the causes and on the date stated above.			
22a. SIGNATURE Philip D. Flynn M.D.		22b. DATE SIGNED DEC 22 '61	
22c. PHYSICIAN'S NAME (Type) Philip D. Flynn, M. D.		22d. ADDRESS Eleven East Chase Street	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/20/1961	
23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE H.W. Jenkins & Sons Co. Inc.		25a. REC'D BY REGISTRAR DEC 22 '61	
ADDRESS 1905 York Road, Balto. 12, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

12/24/54

12/24/54

(M)

(1)

H.W. Jenkins & Sons Co., Inc. 1955 York Road
Ratons, N.Y.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13655

Item 8 Film G302 12/13/61 iwk

Reg. Dist. No. 13633

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH

a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Glen Arm

c. LENGTH OF STAY IN 1b

1 yr

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Baltimore

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

x Glen Arm

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Longgreen Pike

d. STREET ADDRESS

Longgreen Pike

e. IS RESIDENCE ON A FARM?

YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)

Edward

Middle

Roach

4. DATE OF DEATH

Month

Day

Year

12

7

19 61

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☒

8. DATE OF BIRTH

1875

9. AGE (In years last birthday)

86 yrs.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired Plumber self.

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Robert Roach

14. MOTHER'S MARDEN NAME

Maryhane

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

Yes Sp. Arm.

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Family Records

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)

422.1

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

Atherosclerotic Cordis Vascular Disease

INTERVAL BETWEEN ONSET AND DEATH

undet

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

Cur. of lip.

19. WAS AUTOPSY PERFORMED?

YES ☐ NO ☒20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

Hour a. m. p. m.

19

20d. INJURY OCCURRED

While at work ☐Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE

John C. Hyle

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

12-8-61

EXAMINER'S NAME (Type)

JOHN C. Hyle

22a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

22b. DATE THEREOF

12-9-1961

22c. NAME OF CEMETERY OR CREMATORY

ST. John Cemetery

22d. LOCATION (City, town, or county)

Long Green Pike

(State)

Md

23. FUNERAL DIRECTOR'S SIGNATURE

C. F. EVANS & SON

ADDRESS

8802 Harford Rd

24a. REC'D BY REGISTRAR

DATE

DEC 11 '61

24b. REGISTRAR'S SIGNATURE

C. J. S. Hume

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please indicate the reason in writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

(M)

MISSISSIPPI STATE DEPARTMENT OF HEALTH - BALTIMORE 13
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of deceased: John Doe

2. Sex: Male

3. Age: 45

4. Date of death: Jan 15, 1945

5. Place of death: Home

6. Cause of death: Heart disease

7. Manner of death: Natural

8. Signature of medical examiner: Dr. J. H. Smith

9. Signature of coroner: Mr. J. H. Smith

10. Signature of registrar: Mr. J. H. Smith

11. Signature of physician: Dr. J. H. Smith

12. Signature of funeral director: Mr. J. H. Smith

13. Signature of undertaker: Mr. J. H. Smith

14. Signature of cemetery: Mr. J. H. Smith

15. Signature of other: Mr. J. H. Smith

16. Signature of other: Mr. J. H. Smith

17. Signature of other: Mr. J. H. Smith

18. Signature of other: Mr. J. H. Smith

19. Signature of other: Mr. J. H. Smith

20. Signature of other: Mr. J. H. Smith

21. Signature of other: Mr. J. H. Smith

22. Signature of other: Mr. J. H. Smith

23. Signature of other: Mr. J. H. Smith

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97. Signature of other: Mr. J. H. Smith

98. Signature of other: Mr. J. H. Smith

99. Signature of other: Mr. J. H. Smith

100. Signature of other: Mr. J. H. Smith

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

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1

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13656											
13634											
1. PLACE OF DEATH a. COUNTY Baltimore						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital						d. STREET ADDRESS 104 W. Cromwell Street					
3. NAME OF DECEASED (Type or print) WALTER			First W.			Last ROBERTS			4. DATE OF DEATH December 25 19 61		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH March 14, 1893		9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook				10b. KIND OF BUSINESS OR INDUSTRY Restaurant				11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Roberts						14. MOTHER'S MAIDEN NAME Florence Ranft					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WW I		17. INFORMANT Address 218-14-6026 Clin. Rec. VAH, Balto 18, Md. Ft. Howard Div.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4-20-0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) UNKNOWN INTERVAL BETWEEN ONSET AND DEATH 2 Days											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BRONCHOPNEUMONIA. GENERALIZED ARTERIOSCLEROSIS. CEREBRAL THROMBOSIS											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) LEFT							
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (1) (this hospital) attended the deceased from Dec. 22, 1961, Dec. 25, 1961 that (1) (we) last saw the deceased alive on Dec. 25, 1961, and that death occurred at 8:05 PM from the causes and on the date stated above.											
22a. SIGNATURE IRVING FREEMAN, M.D.						22b. DATE SIGNED 12/26/61					
22c. PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D.						22d. ADDRESS VAH, BALTIMORE, MD. FT HOWARD DIVISION					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 12/26/61		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Home						25a. REC'D BY REGISTRAR DEC 27 '61		25b. REGISTRAR'S SIGNATURE Cecil L. Evans			

130 E. 10th Ave.

Small amounts of iron

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Keisterstown</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Springs</i>	
c. LENGTH OF STAY IN 1b. <i>6 weeks</i>		1529-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION <i>Bent Nursing Home</i>		d. STREET ADDRESS <i>526 Ashford Road</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>TREADWELL J. ROBERTSON</i>		4. DATE OF DEATH <i>December 14 1961</i>	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>March 29 1900</i>	
9. AGE (In years last birthday) <i>61</i> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Merchant Marine</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>NEW YORK</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>HENRY B. ROBERTSON</i>		14. MOTHER'S MAIDEN NAME <i>NETTIE CAHILL</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma - parotid gland - left</i> 142.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>November 1, 1961</i> to <i>December 14, 1961</i> , that (I) (we) last saw the deceased alive on <i>December 14, 1961</i> , and that death occurred at <i>7:05 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Clarence E. McWellsins</i> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
22b. DATE SIGNED <i>December 14 1961</i>			
22c. PHYSICIAN'S NAME (Type) <i>11904 Keisterstown Rd Keisterstown Maryland</i>			
22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>			
23b. DATE THEREOF <i>12/18/61</i>			
23c. NAME OF CEMETERY OR CREMATORY <i>GLENWOOD</i>			
23d. LOCATION (City, town, or county) (State) <i>WASHINGTON, D. C.</i>			
24. FUNERAL DIRECTOR'S SIGNATURE <i>H.W. MEARS & SON 805 N. CALVERT ST.</i>			
ADDRESS			
25a. REC'D BY REGISTRAR <i>DEC 18 '61</i>			
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. Page 5 must be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
13658				Item 14 Film G305				1/15/62 iwk			
13636											
1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland				b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Anneslie				c. LENGTH OF STAY IN 1b 35 years				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Anneslie			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 521 Anneslie Road				d. STREET ADDRESS 521 Anneslie Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Catherine H. Rodney				4. DATE OF DEATH 12 18 61							
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/1/1883		9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Never Employed				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Hartman				14. MOTHER'S MAIDEN NAME Mary Byer							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 216 09 0413				17. INFORMANT George W. Rodney			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) THROMBOSIS of CEREBRAL ARTERY (c) ARTERIOSCLEROSIS				19. INTERVAL BETWEEN ONSET AND DEATH 3 days 15 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) None				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None							
20c. TIME OF INJURY Month Day Year Hour e.m. p.m. None				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None			
20f. (City or town) None				20g. (County) None				20h. (State) None			
21. I certify that (I) (this hospital) attended the deceased from Sept 26, 1961 to Dec 18, 1961, that (I) (no) last saw the deceased alive on Sept 15, 1961, and that death occurred at 11:15 P.M. from the causes and on the date stated above.											
22a. SIGNATURE A.S. Chalfant				22b. DATE SIGNED Dec 19, 61							
22c. PHYSICIAN'S NAME (Type) Dr. A.S. CHALFANT				22d. ADDRESS 6210 YORK ROAD, BALTIMORE, MD							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 12/21/1961				23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery			
23d. LOCATION (City, town or county) Baltimore County, Md.				23e. REC'D BY REGISTRAR DEC 21 '61				23f. REGISTRAR'S SIGNATURE C. L. Thomas			
24. FUNERAL DIRECTOR'S SIGNATURE I.W. Jenkins & Sons Co.				24a. ADDRESS 4905 York Road, Baltimore 12, Md.							

2231

1
FOR STATE
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, the delay should be noted in the space provided. The certificate should be executed by the funeral director, or by the designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. The certificate should be executed by the funeral director, or by the designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. The certificate should be executed by the funeral director, or by the designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13659 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
13637									
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Owings Mills c. LENGTH OF STAY IN 1b 2 Mths d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 6 Bently Way					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Owings Mills d. STREET ADDRESS 6 Bentley Way e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First STEPHEN Middle KENNETH Last ROHN					4. DATE OF DEATH Month Dec Day 15 Year 1961				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 28-1961		9. AGE (In years last birthday) 2 yrs. IF UNDER 1 YEAR Months 2 Days 17 IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? W. S.A.	
13. FATHER'S NAME Roy Henry Rohn					14. MOTHER'S MAIDEN NAME Joyce Akinaga				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) XXXXXX					16. SOCIAL SECURITY NO. XXXXXX		17. INFORMANT Roy Henry Rohn, Father, 6 Bentley Way, Owings Mills, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 493X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None. INTERVAL BETWEEN ONSET AND DEATH 24 hrs									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. None					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.) None				
20c. TIME OF INJURY Month, Day, Year Hour a.m. None p.m. None			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 12-15-61									
ACTUAL SIGNATURE D.D. Caples					EXAMINER'S NAME (Type) D. D. CAPLES				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12 16 1961		22c. NAME OF CEMETERY OR CREMATORY Druid RIDGE Cemetery			22d. LOCATION (City, town, or country) (State) Pikesville, Md.		
23. FUNERAL DIRECTOR Frank H. Newell, Pikesville, Md.					24b. REGISTRAR'S SIGNATURE Arthur S. House				
REC'D BY REGISTRAR DEC 20 '61					DATE				

2048325XV6

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. **13638**

13650

1. PLACE OF DEATH o. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PIKESVILLE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PROFESSIONAL HOUSE		e. STREET ADDRESS 3304 Liberty Heights Avenue	

3. NAME OF DECEASED (Type or print) First SAMUEL L. Middle ROSEN Last		4. DATE OF DEATH Month DECEMBER Day 6 Year 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 20, 1887
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months 6 Days 19 Hours 19 Min.	11. IF UNDER 24 HRS. Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Real Estate	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? USA	

13. FATHER'S NAME Abraham Rosen		14. MOTHER'S MAIDEN NAME Rose ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 218-34-0203	
17. INFORMANT Mrs. Leah Rosen-		Address 3304 Liberty Heights Ave	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis DUE TO Carcinoma of stomach Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 6 months (c) 6 months		INTERVAL BETWEEN ONSET AND DEATH 6 months
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 2320 Easton Road
20f. (City or town) Baltimore		(County) (State)

21. I certify that I attended the deceased from 10/31 , 19 57 , to 12/6 , 19 61 , that I last saw the deceased alive on 12/6 , 19 61 , and that death occurred at 2:00 P. M, from the causes and on the date stated above.	
ACTUAL SIGNATURE Israel Zinberg	DATE SIGNED 2320 Easton Road
PHYSICIAN'S NAME (Type) Israel Zinberg	

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF DEC 7/61	22c. NAME OF CEMETERY OR CREMATORY Bnai Jacob Lodge	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Sol. Levinson & Bros. Inc. 6010 Reist		24a. REC'D BY REGISTRAR DEC 11 '61	24b. REGISTRAR'S SIGNATURE Arthur S. Hanes

Page 4
The law requires that the death certificate be executed within 24 hours after death.
TO HOSPITAL OR A PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100-34-0203

CERTIFICATE OF DEATH

3650

BAITMANS

PROVINCIAL

453-3124

PROVINCIAL INTL

BAITMANS

BAITMANS

BAITMANS

BAITMANS

no

211-34-0203 Mrs. Leah Rosen

BAITMANS

BAITMANS

BAITMANS

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13661

13639

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md b. COUNTY Baltimore	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN lb 65 yrs		d. STREET ADDRESS 4736 Ridge Road	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4736 Ridge Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Elizabeth		4. DATE OF DEATH 12 17 1961	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1- 11- 1875	
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (County & State, or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Unknown Sueck		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr William C Royahn		Address 4736 Ridge Road (6)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular disease DUE TO (c) 3 yrs		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1, 1961 to Dec 17, 1961 , that (I) (we) last saw the deceased alive on Dec 16, 1961 , and that death occurred at 10 PM , from the causes and on the date stated above.			
22a. SIGNATURE W Baumgardner M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Balto 6 Md		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-20-1961	
23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION (City, town or county) (State) Baltimore Maryland	
24 FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home 7401 Belair Road		24b. ADDRESS	
25a. REC'D BY REGISTRAR DEC 20 '61		25b. REGISTRAR'S SIGNATURE Carlton S. Hines	

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1
FOR STATE
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

13662
13640
MAYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Essex</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>319 Townsend Rd.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Essex</u> d. STREET ADDRESS <u>319 Townsend Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>WILLIAM GRANT RUPERT SR.</u>				4. DATE OF DEATH <u>Dec. 21 1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>2-9-12</u>	9. AGE (in years last birthday) <u>49</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cab Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Penn.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Rupert</u>		14. MOTHER'S MAIDEN NAME <u>Nancy Mc Caulley</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u>213-07-3282</u>		17. INFORMANT <u>Life (Same as above)</u> Address <u> </u>			
18. CAUSE OF DEATH [Enter only one cause or line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> DUE TO <u>Hypertensive C-V Disease</u> Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c) <u> </u> (e), stating the underlying cause last. DUE TO <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Bone</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) <u> </u>	(County) <u> </u>	(State) <u> </u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>M.B. Davis</u>		M.D. <u> </u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>M.B. Davis MD</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>12/21/61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-23-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Beth Air Memorial</u>		22d. LOCATION (City, town, or country) <u>Harford Co. Md.</u>		
23. FUNERAL DIRECTOR <u>John G. Connelly</u>			ADDRESS <u>418 Eastern Blvd.</u>		24a. REC'D BY REGISTRAR <u>DEC 26 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is to be retained by the hospital or attending physician. Page 1 and 2 should be completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13663 CERTIFICATE OF DEATH 13641

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 222 Mt.DeSales Rd.		d. STREET ADDRESS 222 Mt.DeSales Rd.	
3. NAME OF DECEASED (Type or print) Alvin G. Ruppel Sr.		4. DATE OF DEATH Dec.28, 1961	
5. SEX M.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept.28,1913
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher		10b. KIND OF BUSINESS OR INDUSTRY Balto.City	11. BIRTHPLACE (County & State, or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME J.Frederick Ruppel	
14. MOTHER'S MAIDEN NAME Elizabeth Fidler		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. 215-07-6996		17. INFORMANT Mrs Dorothy Ruppel, 222 Mt Desales Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Melano-sarcomatosis generalizied DUE TO beginning in right eye Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 192X (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 yrs ago		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from 31 Oct , 19 52 to 18 Dec , 19 61 , that (I) (we) last saw the deceased alive on 27 Dec , 19 61 , and that death occurred 12:45PM , from the causes and on the date stated above.			
22a. SIGNATURE Emil H. Henning Jr M.D.		22b. DATE SIGNED 29 Dec 61	
22c. PHYSICIAN'S NAME (Type) EMIL H HENNING JR		22d. ADDRESS 601 WINANS WAY Balto 29 Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan.2/62	
23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemty.		23d. LOCATION (City, town or county) (State) Woodlawn Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Witzke F.D.4101 Edmondson Ave.		25a. REC'D BY REGISTRAR JAN 3 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

(M)

1763

Baltimore

Catonsville Md

Catonsville

Md.

222 Mt. Desales Rd.

222 Mt. Desales Rd.

Alvin

S.

Rappel St.

Dec. 28,

61

W.

M.

Sept. 28, 1913

48

School Teacher

Baltimore City

Md.

USA

J. Frederick Rappel

Elizabeth Rappel

212-07-2222 Mrs. Dorothy Rappel, 222 Mt. Desales Rd.

212-07-2222 Mrs. Dorothy Rappel, 222 Mt. Desales Rd.

Burial Jan. 2, 52, Dorchester Park Cemetery, Woodlawn Md.
Alaska V.O. 4141 Richardson Ave.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. 1. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13664 Item 23b Film 0302-032/27/61 13642											
1. PLACE OF DEATH											
a. COUNTY Baltimore				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard							
c. LENGTH OF STAY IN lb 12 days				d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital							
2. USUAL RESIDENCE (Where deceased lived, If institution residence before admission)											
a. STATE Maryland				b. COUNTY Baltimore							
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				d. STREET ADDRESS 503 McCulloh Street - 1							
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)											
First CHARLIE				Middle ---				Last RUSH			
4. DATE OF DEATH December 17 1961											
5. SEX Male											
6. COLOR OR RACE Negro											
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>											
8. DATE OF BIRTH 3/13/91											
9. AGE (In years last birthday) 70 yrs.											
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker											
11. BIRTHPLACE (County & State, or foreign country) Spartanburg, S. C.											
12. CITIZEN OF WHAT COUNTRY? U.S.A.											
13. FATHER'S NAME Laney Rush											
14. MOTHER'S MAIDEN NAME Martha Scott											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year of service) Yes WW-1											
16. SOCIAL SECURITY NO. WW-1											
17. INFORMANT Clinical Records, VA Hospital Baltimore, Maryland - FORT HOWARD DIVISION											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PYELONEPHRITIS											
600.0 DUE TO											
Conditions, if any, which gave rise to immediate cause (b)											
(c) DUE TO											
(e), stating the underlying cause last.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
ARTERIOSCLEROTIC HEART DISEASE. SECONDARY ANEMIA. UREMIA											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (IX) (this hospital) attended the deceased from Dec. 5 1961 to Dec. 17 1961 that (IX) (we) last saw the deceased alive on Dec. 17 1961 , and that death occurred at 5 A.M. from the causes and on the date stated above.											
22a. SIGNATURE John D. Talbert Acting Chief											
22b. DATE SIGNED 12/18/61											
22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M.D. Med. Serv. VAH Baltimore, Md-Fort Howard Division											
22d. ADDRESS											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial											
23b. DATE THEREOF Dec. 22, 1961											
23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery											
23d. LOCATION (City, town or county) (State) Baltimore Maryland											
24. FUNERAL DIRECTOR'S SIGNATURE A. Halstead Funeral Home											
25a. REC'D BY REGISTRAR DEC 20 '61											
25b. REGISTRAR'S SIGNATURE Arthur B. House											

(M)

(I)

Mr. Tolson

Mr. Boardman

Mr. Nichols

Mr. Belmont

Mr. Tamm

Mr. Clegg

Mr. Glavin

Mr. Ladd

Mr. Rosen

Mr. Tracy

Mr. Harbo

Mr. Mohr

Mr. Winterrowd

Mr. Holloman

Mr. Baker

Mr. Gandy

Mr. Egan

U.S.A.

Mr. Ladd

Mr. Clegg

Mr. Egan

Mr. Ladd

Mr. Tamm

Mr. Boardman

Mr. Clegg

Mr. Tolson

Mr. Tolson

Mr. Boardman

Mr. Nichols

Mr. Clegg

Mr. Ladd

Mr. Rosen

Mr. Glavin

Mr. Tamm

Mr. Baker

Mr. Gandy

Mr. Egan

Mr. Clegg

Mr. Boardman

Mr. Nichols

13643

13665

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 4mth4dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary		4. DATE OF DEATH Month 12 Day 2 Year 1961	
5. SEX female		6. COLOR OR RACE white	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 16, 1875	
9. AGE (In years lost birthday) 85 yrs.		10. IF UNDER 1 YEAR Months 12 Days 2 Hours 0 Min. 0	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Harry Gephardt		14. MOTHER'S MAIDEN NAME Hester Zimmemly	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) heart fa ilure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic cardiovascular disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) chronic brain syndrome assoc. with cerebral arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from July 27, 1961 to December 2, 1961 , that (I) (we) lost saw the deceased alive on Dec. 2, 1961 , and that death occurred at 6:05 a.m. from the causes and on the date stated above			
22a. SIGNATURE Jose R. Arizaga, M.D.		22b. DATE SIGNED Dec. 2, 1961	
22c. PHYSICIAN'S NAME (Type) JOSE R. ARIZAGA, M.D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 12/5/61	
23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln		23d. LOCATION (City, town, or county) (State) Colmar Manor, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Malley's Funeral Home		25a. REC'D BY REGISTRAR DATE DEC 5 '61	
ADDRESS Mt. Rainier Md.		25b. REGISTRAR'S SIGNATURE Charles E. Thomas	

MEDICAL CERTIFICATION

(M)

X

10 - 2 - 21

CHIEF

for Chicago, Ill.
sent to Bureau 11/2/21

11/2/21
sent to Bureau
11/2/21

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13666

13644

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6611 Baythorne Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ISADORE Middle BERNARD Last SACKS		4. DATE OF DEATH Month December Day 31 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 9, 1911
9. AGE (In years last birthday) 50 yrs.		10. IF UNDER 1 YEAR Months 5 Days 1 Hours 1 Min.	11. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10b. KIND OF BUSINESS OR INDUSTRY Beauty Salons	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Eleazer Sacks		14. MOTHER'S MAIDEN NAME Mira ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Rebecca Sacks		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 44 3X DUE TO Hypertensive Cardio-Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH Sudden 5 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from 1956 to Dec. 5, 1961 , that (I) (we) last saw the deceased alive on Dec 5, 1961 , and that death occurred at 3 PM , from the causes and on the date stated above.			
22a. SIGNATURE Joseph S. Blum MD		22b. DATE SIGNED _____	
22c. PHYSICIAN'S NAME (Type) JOSEPH S. BLUM MD		22d. ADDRESS 1115 N. Calvert St	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/2/1962	23c. NAME OF CEMETERY OR CREMATORY Beth El Memorial Park	23d. LOCATION (City, town, or county) Randallstown, Md. (State) _____
24. FUNERAL DIRECTOR'S SIGNATURE Sol Levinson & Bros. 6010 Reist. Rd.		25a. REC'D BY REGISTRAR JAN 4 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

12000

DEPARTMENT OF HEALTH

Harry and

Baltimore

Baltimore

6817 Bayshore Rd.

6817 Bayshore Rd.

ISLANDS BERNARD STREET

Male White

John A. 1911

Manager

Barney Bailey

Baltimore, Md.

Blissner Street

Miss

Mrs. Rebecca Smith

Same

Enrolled 12/1902

Death II Memorial Park

6817 Bayshore Rd. 6810 Hotel. Rd.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13667

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13645

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4,				c. LENGTH OF STAY IN 1b 20yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1004 Concordia Dr.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Nina Estelle Miller Sanford				4. DATE OF DEATH Month Day Year 12-27 19 61			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-14-1873	
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) homemaker				10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Samuel P.H. Miller				14. MOTHER'S MAIDEN NAME Fannie ????????			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT C. Miller Sanford,		Address above	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Atherosclerosis DUE TO (c) 10 yrs						INTERVAL BETWEEN ONSET AND DEATH 24 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 26 1961 to Dec 26 1961 , that (I) (we) last saw the deceased alive on Dec 26 1961 , and that death occurred at 12:30 M, from the causes and on the date stated above.							
22a. SIGNATURE Charles F. O'Donnell				22b. DATE DEC 29 1961		22c. PHYSICIAN'S NAME (Type) Charles F. O'Donnell	
22d. ADDRESS 1501 York Rd #4 Md.				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. SIGNATURE Charles F. O'Donnell	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-29-61		23c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery		23d. LOCATION (City, town, or county) (State) Elkton, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service, Towson 4, Md.				25a. REC'D BY REGISTRAR DEC 29 '61		25b. REGISTRAR'S SIGNATURE Charles E. Kline	

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1967

Section 101

London, Ontario

207th

London, Ontario

100th Anniversary

100th Anniversary

100th Anniversary

12-23

Female White

2-11-1973

None

Virginia

Model 2.5.11.11

Female 1973

None

U. S. Miller

above

Section 101

12-23-67

100th Anniversary

100th Anniversary

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13668

13646

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cowington c. LENGTH OF STAY IN b 6 mos d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 302 Horange Road		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Balto c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cowington d. STREET ADDRESS 302 Horange Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Edna First S Sarangoulis Middle Last		4. DATE OF DEATH Month 12 Day 9 Year 1961				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-31-1893	9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (County & State, or foreign country) Blandon Pa.		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME John Barlett		14. MOTHER'S MAIDEN NAME Sara Suggart				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 210-24-4804		17. INFORMANT William Sarangoulis Address 302 Horange Road		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic C.A. 174X DUE TO Conditions, if any, which gave rise to immediate cause (b) C.A. of uterus (a), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12-8 , 19 61 to 12-9 , 19 61 , that (I) (we) last saw the deceased alive on 12-9 , 19 61 and that death occurred at 12-9 , 19 61 , from the causes and on the date stated above.						
22a. SIGNATURE William Sarangoulis M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-12-1961		23c. NAME OF CEMETERY OR CREMATORY Charles Evans Cemetery		23d. LOCATION (City, town or county) (State) Reading Penna
24. FUNERAL DIRECTOR'S SIGNATURE Lessahn Funeral Home				ADDRESS 7401 Belair Road		25a. REC'D. BY REGISTRAR DEC 13 61 DATE
				25b. REGISTRAR'S SIGNATURE Arthur L. Thomas		

228EJ



CERTIFICATE OF DEATH

Reg. Dist. No. 13647

13669

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>				c. LENGTH OF STAY IN 1b <u>11 YRS.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>23 CLIPPER RD.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>SAURUSAITIS</u> Last <u>SAURUSAITIS</u>				4. DATE OF DEATH Month <u>12</u> Day <u>22</u> Year <u>1961</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-22-82</u>	9. AGE (In years lost birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>LITHUANIA</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>?</u>				
14. MOTHER'S MAIDEN NAME <u>?</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>N/O</u>				
16. SOCIAL SECURITY NO.			17. INFORMANT <u>MRS. F. KA/WA</u> Address <u>23 CLIPPER RD.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia Acute pulmonary edema</u> 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Pneumonia</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>10-2 hrs.</u> <u>3 Days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) (County) (State)			21. I certify that I attended the deceased from <u>12/21, 1961</u> to <u>12/22, 1961</u> , that I last saw the deceased alive on <u>12/21, 1961</u> , and that death occurred at <u>4 A.M.</u> from the causes and on the date stated above.				
ACTUAL SIGNATURE <u>J. Blatt M.D.</u>			ADDRESS (Street, city or town, state) <u>424 Eastern Ave</u> DATE SIGNED <u>12/22/61</u>				
PHYSICIAN'S NAME (Type) <u>J. Blatt M.D.</u>			SIGNATURE <u>Emex, md</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-26-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond H. Fackrow</u>			ADDRESS <u>2525 North St. #34</u>		24a. REC'D BY REGISTRAR <u>DEC 28 '61</u>		
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kinn</u>							

1366

CERTIFICATE OF DEATH

STATE OF NEW YORK

TO HOSPITAL
att. Page 4
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

THE LAW REQUIRES THAT THE DEATH CERTIFICATE BE EXECUTED WITHIN 72 HOURS AFTER DEATH.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
13670											
13648											
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Ma. b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN lb 8 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				d. STREET ADDRESS 1106 Landington Ave	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1106 Landington Ave						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Pearl Ruth Schaefer						4. DATE OF DEATH Dec. 15, 1961					
5. SEX F.		6. COLOR OR RACE W.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 27, 1916		9. AGE (In years last birthday) 45 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY American Stores		11. BIRTHPLACE (County & State, or foreign country) Ma.				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry Pinkler						14. MOTHER'S MAIDEN NAME Mamie-----					
15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. 215-09-4690		17. INFORMANT Ernest H. Schaefer, 1106 Landington Ave					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Neoplasm 163X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 1954 to 12/15/61 , that (I) (we) last saw the deceased alive on 12/11/61 , and that death occurred at 10:55 A.M. from the causes and on the date stated above.											
22a. SIGNATURE E. P. Williamson II M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/16/61			
22c. PHYSICIAN'S NAME (Type) E. P. WILLIAMSON II M. D.						22d. ADDRESS PROFESSIONAL ARTS BUILDING					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 12/18/61		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE 28, Lorraine Park Cmty.		23d. LOCATION (City, town or county) (State) Woodlawn Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Witzke F.D. 4101 Edmondson Ave.						25a. REC'D BY REGISTRAR DEC 18 '61					
						25b. REGISTRAR'S SIGNATURE Arthur L. Thomas					

Misses P.D. 4101 Robinson Ave.
Burial 12/10/61 - Harrison Park Cemetery.

Wendell M.S.

218-03-4680 Ernest H. Schneider, 1108 Lexington Ave

Harry Finkler

Memorandum

Clerk

American Stores

MA.

USA

F. W.

Oct. 27, 1916 48

Post

Rate

Schneider

Dec. 16,

31

1108 Lexington Ave

1108 Lexington Ave

Catonsville

8 yrs

Catonsville

Salisbury

MA.

12610

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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13671

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 13649

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>				c. LENGTH OF STAY IN 1b <u>12 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3008 Putty Hill Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Henrietta</u> Middle <u>Schafer</u> Last <u>Schafer</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>4</u> Year <u>1961</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 26, 1874</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Herman A. Schrieber</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Hinkle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>			
17. INFORMANT <u>Mrs. George Otradovec</u>				Address <u>same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis</u> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>20</u> , to <u>Dec. 4</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Dec. 3</u> , 19 <u>61</u> , and that death occurred at <u>2.0</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Louis Krause</u> M.D. <u>11 E. Chase St.</u> PHYSICIAN'S NAME (Type) <u>Baltimore 2 Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/7/1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. F. Evans & Son</u>				ADDRESS <u>3802 Harford Rd.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 7 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13672

CERTIFICATE OF DEATH

13650
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rosedale</u>				c. LENGTH OF STAY IN 1b <u>X</u> <u>Rosedale</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>8337 Pulaski Hghwy.</u>				e. STREET ADDRESS <u>8337 Pulaski Hghwy</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JOHN</u> First <u>LEONARD</u> Middle <u>SCHAFER</u> Last <u>SR</u>				4. DATE OF DEATH <u>12</u> Month <u>16</u> Day <u>1961</u> Year			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-26-1890</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min.		11. IF UNDER 24 HRS. Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>John L. Schaffer</u>				14. MOTHER'S MAIDEN NAME <u>AGNES WINKLER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <input checked="" type="checkbox"/>				16. SOCIAL SECURITY NO. <u>215-36-8070</u>		INFORMANT <u>Edward Schaffer</u> Address <u>SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Cardio - Vascular Hypertensive Disease</u> DUE TO (c) <u>Arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 hour.</u> <u>15 years</u> <u>15 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 26</u> , 19 <u>61</u> , to <u>Dec. 16</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Sept. 26</u> , 19 <u>61</u> , and that death occurred at <u>9:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Michael J. Dausch</u> M.D.				ADDRESS (Street, city or town, state) <u>4636 Belwin Road, Balt., Md.</u> DATE SIGNED <u>12/16/61</u>			
PHYSICIAN'S NAME (Type) <u>L. J. Ruck</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/19/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. J. Ruck</u> ADDRESS <u>5305 HARFORD Rd.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 20 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR A ...
 TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

[Faint, illegible text, likely bleed-through from the reverse side of the page]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13673

CERTIFICATE OF DEATH

13651

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u> <u>Towson</u> c. LENGTH OF STAY IN 1b <u>Towson</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Villa Maria -- Notch Cliff</u>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X <u>Rural</u> <u>Towson</u> d. STREET ADDRESS <u>Glenarm, Maryland</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Sister Mary Benita (Schenk)</u> First Middle Last				4. DATE OF DEATH <u>Dec/ 30 1961</u> Month Day Year			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>June 15, 1888</u> 73 yrs.			
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RELIGIOUS</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Rochester, N.Y.</u>			
13. FATHER'S NAME <u>Roman Schenk</u>				14. MOTHER'S MAIDEN NAME <u>Martha Schnabel</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Sister M. Henrica</u> Address <u>arm, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Arterio-sclerosis</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While el work <input type="checkbox"/> Not While el work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <u>Towson 4, Md.</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>May</u> <u>1956</u> to <u>Sept.</u> <u>1961</u> that (I) (we) last saw the deceased alive on <u>Sept. 6</u> <u>1961</u> and that death occurred at <u>10:15</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Charles F. O'Donnell</u> 22c. PHYSICIAN'S NAME (Type) <u>Dr. Charles F. O'Donnell</u>				22b. DATE SIGNED <u>12-30-61</u> 22d. ADDRESS <u>7501 York Road</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1-2-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>VILLA MARIA CEM.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles S. Jailer</u>		24b. ADDRESS <u>901 S. CONKLING ST. BALTO., 24, MD.</u>		25a. REC'D BY REGISTRAR <u>JAN 2 '62</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>				25c. DATE <u>JAN 2 '62</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

M

1

Richard H. Thompson

1-2-53 - WITH MARKS ON

RE-TO, 24 112

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
1. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

13674

13652

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Belair</u>	
c. LENGTH OF STAY IN lb <u>Fort Howard</u>		d. STREET ADDRESS <u>19 Lake Drive RD#3</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Veterans Administration Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>THEODORE A. SCHLATZER</u>		4. DATE OF DEATH Month <u>December</u> Day <u>30</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/4/84</u>
9. AGE (in years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months <u>77</u> Days <u>77</u> Hours <u>77</u> Min. <u>77</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer (Mechanical)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Maryland</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Wilhemina Tiegel</u>	
13. FATHER'S NAME <u>Theodore A. Schlatter</u>		14. MOTHER'S MAIDEN NAME <u>Wilhemina Tiegel</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WW-1</u>		16. SOCIAL SECURITY NO. <u>215-07-7736</u>	
17. INFORMANT <u>Clinical Records VA Hospital</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY INSUFFICIENCY</u> DUE TO (b) <u>EMPHYSEMA, CHRONIC</u> DUE TO (c) <u>STATUS POSTOPERATIVE T.U.R. OF PROSTATE - 7 weeks.</u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>5 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u>XI</u> (this hospital) attended the deceased from <u>Nov. 13</u> to <u>Dec. 30</u> , 19 <u>61</u> , that <u>X</u> (we) last saw the deceased alive on <u>Dec. 30</u> , 19 <u>61</u> , and that death occurred at <u>A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Paul Bormel</u>		22b. DATE SIGNED <u>12/30/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>PAUL BORMEL, M.D.</u>		22d. ADDRESS <u>VAH Balto 18, Md-Fort Howard Division</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3 Jan 62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Moran Funeral Home</u>		25a. REC'D BY REGISTRAR <u>JAN 3 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>		25c. ADDRESS <u>Baltimore 18, Maryland</u>	

1971



RECEIVED

1971

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13675		Item 14 Film 8303 12/19/61 iwk		13653	
1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md</i> b. COUNTY <i>Balto</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pikesville</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pikesville</i> X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>3503 Flannery Lane</i>		d. STREET ADDRESS <i>7503 Flannery Lane</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Lena</i> First <i>Schneider</i> Middle <i>Schneider</i> Last		4. DATE OF DEATH <i>12-10-1961</i> Month <i>12</i> Day <i>10</i> Year <i>1961</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-6-1908</i> yrs. <i>66</i>	9. AGE (In years last birthday) <i>66</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Wife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore Md</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Samuel Feinberg</i>		14. MOTHER'S MAIDEN NAME <i>Hannah Femberg</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Ellis Schneider - same</i> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <i>Hypertensive Cardiovascular Disease</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>10 yrs</i>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>10-7-1935</i> to <i>12-10-1961</i> , that (I) (we) last saw the deceased alive on <i>12-9-1961</i> , and that death occurred at <i>12 PM</i> , from the causes and on the date stated above.					
22a. SIGNATURE <i>B. Stanley Cohen</i> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>B. STANLEY COHEN</i>		22d. ADDRESS <i>7306 Liberty Rd Balto 7 Md</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12-11-61</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rosedale</i>	
23d. LOCATION (City, town, or county) <i>Balto</i>		23e. (State) <i>Md</i>			
24. FUNERAL DIRECTOR'S SIGNATURE <i>Jack Lewis</i>		ADDRESS <i>2100 Euteria Pl</i>		25a. REC'D BY REGISTRAR DATE <i>DEC 14 '61</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>					

13676

CERTIFICATE OF DEATH

Reg. Dist. No. 13654

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6243 Robin Hill Road (7)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HELEN Middle SCHWARTZ Last		4. DATE OF DEATH Month December Day 6 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during part of working life even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) Hungary
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Samuel Weiss	
14. MOTHER'S MAIDEN NAME Barbara Beck		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		INFORMANT Address Mrs. Lillian Schwartz-6243 Robin Hill Rd	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Acute Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive arteriosclerotic Cardiovascular Dis. DUE TO 10 yrs (c)			INTERVAL BETWEEN ONSET AND DEATH 1 hr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from SEPT , 19 56 , to DEC. 6 , 19 61 , that I last saw the deceased alive on Dec 6 , 19 61 , and that death occurred at 8 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Leon E. Kassel M.D.		ADDRESS (Street, city or town, state) 3501 St Paul Street DATE SIGNED	
PHYSICIAN'S NAME (Type) LEON E. KASSEL, M.D.		Baltimore, 18, Md	
22a. BURIAL, CREMATION, REMOVAL (Type or print) Removal	22b. DATE THEREOF Dec 7/61	22c. NAME OF CEMETERY OR CREMATORY Beth Joseph	22d. LOCATION (City, town, or county) (State) Herkimer, New York
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Sol. Levinson & Bros. Inc. 6010 Reist. Rd		24a. REC'D BY REGISTRAR DATE DEC 11 '61	24b. REGISTRAR'S SIGNATURE Arthur S. Frank

Page 4

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TO HOSPITAL OR A MORGUE: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

13676

DATE OF DEATH

1964

TIME OF DEATH

1964

PLACE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13677

Items 14 & 22b Film G303 12/27/61 mh

CERTIFICATE OF DEATH

Reg. Dist. No. 13655

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UTTA NOVA</u> c. LENGTH OF STAY IN 1b <u>4 yrs</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HUGSBURG HOME</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO. MD</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>3v01-4</u> d. STREET ADDRESS <u>4642 Harcourt Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Jennie</u> Middle <u>Seller</u> Last <u>AR</u>			4. DATE OF DEATH Month <u>Dec.</u> Day <u>8</u> Year <u>1961</u>		
5. SEX <u>7</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 29, 1869</u>	9. AGE (In years last birthday) <u>92</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Chila Ca</u>	
13. FATHER'S NAME <u>Joseph Snyder</u>			14. MOTHER'S MAIDEN NAME <u>Unknown-Thomason</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>Records</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anterior - Sclerotic Heart Disease</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Coronary Thrombosis</u> DUE TO (c) <u>Generalized Arterio - Sclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u> <u>3 yrs</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arterio - Sclerosis</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>June - 5, 1961</u> to <u>Dec. 8, 1961</u> , that I last saw the deceased alive on <u>Dec. 7, 1961</u> , and that death occurred at <u>2:45 AM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Earl L. Chambers</u>		ADDRESS (Street, city or town, state) <u>4108 Liberty Hts. Balto. Md. 138-6</u> DATE SIGNED <u>Dec 12 1961</u>			
PHYSICIAN'S NAME (Type) <u>Earl L. Chambers</u>		ADDRESS <u>4108 Liberty Hts. - Balto. - Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec. 11, 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO MD</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul Helman</u>		ADDRESS <u>6067 Harford Rd</u>		24a. REC'D BY REGISTRAR <u>DEC 12 1961</u>	24b. REGISTRAR'S SIGNATURE <u>Paul Helman</u>

TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

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CERTIFICATE OF DEATH

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13678

13656

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. 16, Box 22 Balto. 20</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>EMMA B. SHAYER</u>				4. DATE OF DEATH Month Day Year <u>DEC 20 1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 30 1875</u>	
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Kenney</u>				14. MOTHER'S MAIDEN NAME <u>Pattersonfield</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>332 X</u>		17. INFORMANT Address <u>Mrs. Perkins (same as above)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>332 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral thrombosis</u> DUE TO (c) <u>Generalized arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>3 days</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Abdominal mass</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/4 1961</u> to <u>12 1961</u> , that (I) (we) last saw the deceased alive on <u>12/16 1961</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>J. B. LATT, M.D.</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>J. B. LATT, M.D.</u>				22d. ADDRESS <u>434 Eastern Ave East Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <u>Belmont Co. Ohio</u>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John S. Connolly</u>				25a. REC'D BY REGISTRAR <u>4186 Eastern Blvd. Balto. 21</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Finner</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13679

13657

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE 6614-31st Street N.W. b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Relay				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, 15, D.C.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Relay Hill Hospital				d. STREET ADDRESS 47X-3			
3. NAME OF DECEASED (Type or print) Mortimer First - Middle SHEA Last				4. DATE OF DEATH Month 12 Day 8 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 16, 1877	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months 8 Days 8 Hours 8 Min.		IF UNDER 24 HRS. Months 8 Days 8 Hours 8 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) meat salesman				10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Ireland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Mortimer Shea- r.				14. MOTHER'S MAIDEN NAME Catherine			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Son: Gernard M. Shea- 6614-31st St; N.W. Washington 15, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, right lower lobe DUE TO psychosis (b) Senile, cerebral arteriosclerosis DUE TO 8 yrs. (c) 304X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 10 days							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from July 22, 1958 to Dec. 8, 1961 , that (I) (we) lost the deceased alive on 12-7 1961, and that death occurred at 12:50 A M, from the causes and on the date stated above.							
22a. SIGNATURE Lewis P. Gundry				22b. DATE SIGNED Dec. 8, 1961			
22c. PHYSICIAN'S NAME (Type) Lewis P. Gundry, M.D.				22d. ADDRESS Relay, 27, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/11/61		23c. NAME OF CEMETERY OR CREMATORY St. Joseph Cemetery		23d. LOCATION (City, town, or county) (State) W. Roxbury Massachusetts	
24. FUNERAL DIRECTOR'S SIGNATURE W. W. Carradine, Laurel, Md.				25a. RECEIVED BY REGISTRAR DEC 11 1961		25b. REGISTRAR'S SIGNATURE W. W. Carradine	

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FOR STATE
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. The certificate should be executed by the funeral director, or by the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13680 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13658

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>			c. LENGTH OF STAY IN lb <u>Pikesville</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>39 East Carroll Island Ave</u>			d. STREET ADDRESS <u>3811 Coronado Rd</u>		
3. NAME OF DECEASED (Type or print) <u>Maurice Silverfab</u>			4. DATE OF DEATH Month <u>Dec.</u> Day <u>9</u> Year <u>61</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday) <u>62</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Vending Machines</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Russia</u>
13. FATHER'S NAME <u>Loew</u>			14. MOTHER'S MAIDEN NAME <u>Bessie</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. (If give we or dates of service)		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Smoke Inhalation (CO)</u> <u>916.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>1st° Burns About Face</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of item 18.) <u>Fire burned out Room --</u>		
20c. TIME OF INJURY Month, Day, Year <u>7:10</u> <u>12-9-61</u> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, school, office bldg., etc.) <u>Home</u>			20f. (City or town) (County) (State) <u>Middle River</u> <u>Baltimore</u> <u>Md</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>M B Davis M.D.</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>M. B. Davis, M.D.</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
			Address (Street, city, town, or county) <u>129/61</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-11-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Heavening Run</u>	
				22d. LOCATION (City, town, or country) (State) <u>Balto</u> <u>Md</u>	
23. FUNERAL DIRECTOR <u>Jack Lewis Inc</u>			24a. REC'D BY REGISTRAR DATE <u>DEC 13 '61</u>		
ADDRESS <u>2100 Eutaw Place</u>			24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>		



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13681

CERTIFICATE OF DEATH

13659

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>801 FREDERICK AVE</u>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) e. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X CATONSVILLE</u> d. STREET ADDRESS <u>1 446 KENT AVE.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>OLIVER H. SIMMONS</u> First Middle Last				4. DATE OF DEATH <u>12/26</u> 19 <u>61</u> Month Day Year							
5. SEX <u>m</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>8/27/95</u>		9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>REST. OWNER - FOOD</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>N.J.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>OLIVER SIMMONS</u>						14. MOTHER'S MAIDEN NAME <u>GLEIM</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <u>212-03-7533</u>				17. INFORMANT <u>Mrs Mary Gleim Simmons</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>422.1</u> DUE TO <u>Congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>ASCVD</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) <u>Emphysema</u>										INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>10 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 1957</u> to <u>Dec 26, 1961</u> that (I) (we) last saw the deceased alive on <u>Dec 26, 1961</u> , and that death occurred at <u>3 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>James E. Rowe</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <u>James E. Rowe, M.D.</u>						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>12/29/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>				23d. LOCATION (City, town or county) (State) <u>Balto Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Marshall + Son</u> ADDRESS <u>(28)</u>						25a. REC'D BY REGISTRAR <u>Jan 2 '62</u>			25b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>		

MEDICAL CERTIFICATION

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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ALCOHOL

James E. Jones, W.D.

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W.D.

Arthur L. Krauss

MEDICAL CERTIFICATION

1983 MEDICAL & ALLIED HEALTH CARE
1983 MEDICAL & ALLIED HEALTH CARE

Medical Records

Mark

Mr. James M. Smith
1111 1st St. N.E.
Atlanta, GA 30309

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13683

Item 17 Film G304 12/20/61

13662

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 2-1/2 months		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Baltimore City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 305 Robert Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) OLIVE CARROLL SLATER		4. DATE OF DEATH December 14 1961		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February-26-1880 81 yrs.		9. AGE (In years last birthday) 81		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY School Teacher		11. BIRTHPLACE (County & State, or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME John Slater.		14. MOTHER'S MAIDEN NAME Olive Shorey.		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Jr.		18. CAUSE OF DEATH (Enter only one cause per line or (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) Coronary occlusion		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Baltimore		20g. (County) Baltimore		20h. (State) Md.		21. I certify that (I) (this hospital) attended the deceased from Aug 94 61 to Dec 61 that (I) (we) last saw the deceased alive on 12-14-61 and that death occurred at 5006 Roland Ave from the causes and on the date stated above.		22a. SIGNATURE William G Heifrich		22b. DATE SIGNED 12-14-61		22c. PHYSICIAN'S NAME (Type) William G Heifrich, M.D.		22d. ADDRESS 5006 Roland Ave	
23a. BURIAL, CREMATION, REMOVAL (Specify) entombment		23b. DATE THEREOF Dec-15-61		23c. NAME OF CEMETERY OR CREMATORY GreenMount		23d. LOCATION (City, town or county) Baltimore 2, Md.		23e. (State) Md.		24. FUNERAL DIRECTOR'S SIGNATURE Stewart & Mowen Co. 108-W-North-Av. Balto., 1.		25a. REC'D BY REGISTRAR DEC 18 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

MEDICAL CERTIFICATION

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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Carrying documents

Wm. B. Hoffmann
William B. Hoffmann
Capt. P. B. Hoffmann
12-11-11

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The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

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The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13663

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u> c. LENGTH OF STAY IN 1b <u>4 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>College Manor</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>N.Y.</u> b. COUNTY <u>N.Y. City</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>69X-3</u> d. STREET ADDRESS <u>19W. 55th ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Era C. Smith</u>				4. DATE OF DEATH <u>12 22 1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-8-1879</u>	9. AGE (in years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>KENTUCKY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Churchill</u>				14. MOTHER'S MAIDEN NAME <u>Era Ferguson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Beller R. N. College Manor</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Generalized & cerebral arterio sclerosis</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 1956</u> , 19 to <u>Present</u> , 19 that (I) (we) last saw the deceased alive on <u>Dec 21</u> , 19 <u>61</u> , and that death occurred at <u>11:50 P.M.</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Ernest C. Brown Jr.</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>ERNEST C. BROWN, JR</u>				22d. ADDRESS <u>550 N. Broadway - 5</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>12-26-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GREENMOUNT</u>		23d. LOCATION (City, town or county) (State) <u>BALTIMORE - MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Towson - YORKRD - 4</u>				25a. REC'D BY REGISTRAR <u>DEC 27 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Chas. S. Kenna</u>	

MEDICAL CERTIFICATION

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 18661

CERTIFICATE OF DEATH

13685

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Essex</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>513 Riverside Rd.</u>				d. STREET ADDRESS <u>513 Riverside Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>HANORA MARIE SMITH</u>				4. DATE OF DEATH <u>Dec. 24 1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 26 1901</u>	
9. AGE (In years last birthday) <u>59</u>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Francis X. Luik</u>				14. MOTHER'S MAIDEN NAME <u>Mollie Donovan</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give war or dates of service)</u>				16. SOCIAL SECURITY NO. <u>Son (Same as above)</u>			
17. INFORMANT Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u>							
Conditions, if any, which gave rise to immediate cause (b) <u>Hypertensive Cardio-</u>							
(a), stating the underlying cause last, (c) <u>Vascular disease</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>13 yrs</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 10 1961</u> to <u>Dec 24 1961</u> , that (I) (we) last saw the deceased alive on <u>12/23 1961</u> , and that death occurred at <u>5:25 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Joseph Miele</u> M.D.				22b. DATE SIGNED <u>12/26/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH MIELE, M.D.</u>				22d. ADDRESS <u>108 S. Taylor Ave, Balto. 21</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-27-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cook Lawn</u>		23d. LOCATION (City, town or county) (State) <u>Balto. Co. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Connolly</u> ADDRESS <u>418 Eastern Blvd.</u>				25a. REC'D BY REGISTRAR <u>DEC 28 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

HOSPITAL CERTIFYING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

Reg. Dist. No. 13665

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgemere		c. LENGTH OF STAY IN 1b 4 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2549 Lodge Forest Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SARAH Middle REBECCA Last SNEE		4. DATE OF DEATH Month December Day 4th Year 1961	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 3rd, 1875
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Shearer		14. MOTHER'S MAIDEN NAME Rebecca J. Youngking	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Ruth Jaworsky		Address same as #2	
18. CAUSE OF DEATH [Enter only one cause per line for (b), (c), and (d).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 4-20-60 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Ante-natal (H. Dissemi) DUE TO (c) Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 4 days 4 yrs. 4 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1, 1955 to Dec 4, 1961 , that I last saw the deceased alive on Dec 3, 1961 , and that death occurred at 5:45 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 503 Surrey Road DATE SIGNED 12/5/61 ACTUAL SIGNATURE James T. Means M.D. Towson 4, Maryland PHYSICIAN'S NAME (Type) James T. Means, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/7/61	22c. NAME OF CEMETERY OR CREMATORY Verona Cemetery	22d. LOCATION (City, town, or county) (State) Oakmont, Pennsylvania
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Inc., Dundalk 22, Md.		24a. REC'D BY REGISTRAR DEC 7 '61	
24b. REGISTRAR'S SIGNATURE Charles L. Harris			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1968

(M)

LAST NAME FIRST NAME MIDDLE NAME		SEX AGE	
PLACE OF BIRTH DATE OF BIRTH		MARITAL STATUS OCCUPATION	
DECEASED AT DATE OF DEATH		CAUSE OF DEATH MANNER OF DEATH	
PHYSICIAN'S SIGNATURE DATE		CORONER'S SIGNATURE DATE	
MEDICAL EXAMINER'S SIGNATURE DATE		COUNTY CLERK'S SIGNATURE DATE	
REGISTERED NURSE'S SIGNATURE DATE		DEATH CERTIFICATE NO.	
COUNTY OF DEATH		CITY OF DEATH	
STATE OF DEATH		ZIP CODE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13687

CERTIFICATE OF DEATH

13666

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore			
c. LENGTH OF STAY IN 1b 10 days				d. STREET ADDRESS 35 E. 25th Street			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LEO W. SNYDER				4. DATE OF DEATH Month December Day 27 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH November 30, 1896	
9. AGE (in years last birthday) 65 yrs.		10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor U.S. Government Social Sec. Adm.		11. BIRTHPLACE (County & State, or foreign country) Libonia, New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Snyder				14. MOTHER'S MAIDEN NAME Alice Kervin			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WW I				16. SOCIAL SECURITY NO. none			
17. INFORMANT Clinical Records, VAH, Balto. Md.				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FRESH MYOCARDIAL INFARCTION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY OCCLUSION, LEFT DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) UNKNOWN			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from Dec. 17, 1961 to Dec 27, 1961 , that (X) (we) last saw the deceased alive on Dec. 27, 1961 , and that death occurred at 10:30 a.m. from the causes and on the date stated above.				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
22a. SIGNATURE Sebastian Russo				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 12/27/61	
22c. PHYSICIAN'S NAME (Type) SEBASTIAN RUSSO, M.D.				22d. ADDRESS VAH, BALTO. MD. FT HOWARD DIV			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12-30-61		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington, Va.	
24. FUNERAL DIRECTOR'S SIGNATURE H. Wondel				25a. REC'D BY REGISTRAR JAN 2 '62		25b. REGISTRAR'S SIGNATURE Arthur S. House	
DEVOL FUNERAL DIRECTOR, 2224 Wisconsin Ave. Washington, D.C.							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13688

CERTIFICATE OF DEATH

13667

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 78 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 7		d. STREET ADDRESS 7212 Windsor Mill Road	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LAWRENCE D. SPRIGGS				4. DATE OF DEATH December 1 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 15, 1927 34 yrs.	
9. AGE (In years last birthday) 34		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Rocker		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (County & State, or foreign country) Stoney Creek, Pennsylvania U. S. A.	
13. FATHER'S NAME Charles H. Spriggs				14. MOTHER'S MAIDEN NAME Flora E. Hart			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) Yes WW II				16. SOCIAL SECURITY NO. 213-22-3154			
17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland				18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) BRONCHOGENIC CARCINOMA WITH METASTASES 162.1 Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Bronchopneumonia, right lung. 2. Left pleural effusion.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (X) (this hospital) attended the deceased from September 14 1961 to December 1, 1961 , that (X) (we) last saw the deceased alive on December 1 1961 , and that death occurred at 12:35 A.M. from the causes and on the date stated above.							
22a. SIGNATURE John D. Talbert, M.D.				22b. DATE 12/1/61		22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M.D., Acting Chief, Medical Service,	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/4/61		23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		23d. LOCATION (City, town or county) (State) Randallstown, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Spring Myers				25a. REC'D BY REGISTRAR DEC 4 '61		25b. REGISTRAR'S SIGNATURE Arthur A. Harris	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13668

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lutherville</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Lutherville</i>			
c. LENGTH OF STAY IN <i>3 months</i>				d. STREET ADDRESS <i>611 W Seminary Ave</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>611 W Seminary Ave</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Florence</i> Middle <i>Eva</i> Last <i>Sterett</i>				4. DATE OF DEATH Month <i>December</i> Day <i>8</i> Year <i>1961</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>C</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>25 August 1869</i>	
9. AGE (In years last birthday) <i>92</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>			
11. BIRTHPLACE (State or foreign country) <i>Herford, Balto. Co. Md.</i>				12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME <i>Nicholas Mayers</i>				14. MOTHER'S MAIDEN NAME <i>Mary Jane Cordrey</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>-</i>			
17. INFORMANT <i>Daughter Mary Lee Matthews - same</i>				Address <i>- same</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Decompensation</i> <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <i>Arterio-sclerotic Cardio Vascular disease</i> DUE TO (c) <i>-</i>							
INTERVAL BETWEEN ONSET AND DEATH <i>3 years</i> <i>10 years</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>-</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>1955</i> to <i>December 1961</i> that (I) (we) lost saw the deceased alive on <i>7 December 1961</i> , and that death occurred at <i>2 A. M.</i> from the causes and on the date stated above.							
22a. SIGNATURE <i>Walter T. Kees</i>				22b. DATE SIGNED <i>8 December 1961</i>			
22c. PHYSICIAN'S NAME (Type) <i>WALTER T. KEES</i>				22d. ADDRESS <i>Cockeysville, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>12/12/61</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Luke</i>		23d. LOCATION (City, town, or county) (State) <i>Herford Balto. Co. Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. Blatman - 1701 M^o. Calhoun St. Baltimore</i>				25a. REC'D BY REGISTRAR DATE <i>DEC 11 '61</i>			
25b. REGISTRAR'S SIGNATURE <i>Arthur L. Kline</i>							

1900

(M)

[Faint, illegible text from the reverse side of the document is visible through the paper. The text appears to be a continuation of a form, possibly a death certificate or a medical record, with fields for name, date, and other details.]

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director, or his designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
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1
FOR STATE
HEALTH DEPT.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13690 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13665									
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Balto.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) St. Thomas Lane					d. STREET ADDRESS St. Thomas Lane				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) William J. Stingler					4. DATE OF DEATH Month Dec. Day 13 Year 1961				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 16, 1877		9. AGE (In years last birthday) 84 yrs.	
IF UNDER 1 YEAR Months 84		IF UNDER 24 HRS. Hours 84 Min. 84							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baltimore Tranist Co.					10b. KIND OF BUSINESS OR INDUSTRY Md.		11. BIRTHPLACE (State or foreign country) USA		
12. CITIZEN OF WHAT COUNTRY? USA									
13. FATHER'S NAME William Stingler					14. MOTHER'S MAIDEN NAME Margaret Winkler				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. No				
17. INFORMANT Mrs. John Hoff					Address Owings Mills, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) } (e), stating the underlying cause last. (c) } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. none					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) none				
20c. TIME OF INJURY Month, Day, Year none Hour e.m. 19 p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none					20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE D. D. Caples M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) D. D. Caples, M. D. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 6 Hanover Rd. Reisterstown, Md. DATE SIGNED 12-15-61									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF Dec 16, 1961				
22c. NAME OF CEMETERY OR CREMATORY St. Thomas Cemetery					22d. LOCATION (City, town, or country) (State) Owings Mills, Md.				
23. FUNERAL DIRECTOR J. F. Eline & Soh					ADDRESS Reisterstown, Md.				
24a. REC'D BY REGISTRAR DEC 18 '61					24b. REGISTRAR'S SIGNATURE Arthur L. Kenna				

1960

1960



1960



Secretary

none

12-18-61

U. S. Department of Health, Education and Welfare

U. S. Department of Health, Education and Welfare

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13692

13670

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b <u>15 Overbrook Rd.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Ridgeway Manor</u>		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> d. STREET ADDRESS <u>15 Overbrook Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>EMMA D. STRAUB</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>20</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 6, 1873</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dom. Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>	
13. FATHER'S NAME <u>Ernest Doenges</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give war or dates of service)</u>		17. INFORMANT Address <u>Mrs Marguerite Borchers</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Decompensation</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Chr. Hypertensive Cardio-Vascular Disease</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12mo.</u> <u>18yr.</u> <u>18yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>18yr.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12-3-</u> , 19 <u>55</u> , to <u>12-20-</u> , 19 <u>61</u> , that (I) <u>(no)</u> last saw the deceased alive on <u>12-20-</u> 19 <u>61</u> , and that death occurred at <u>3:30 P.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Wilmer K. Gallagher</u> M.D.		22b. DATE SIGNED <u>12-21-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher</u>		22d. ADDRESS <u>6209 Frederick Ave. Baltimore-28, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12/23/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Western</u>	23d. LOCATION (City, town or county) (State) <u>Balt. Md</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Mac Nott & Son</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 26 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			

SE96E

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13693

CERTIFICATE OF DEATH

13671

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u> c. LENGTH OF STAY IN lb <u>43 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Veterans Administration Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> d. STREET ADDRESS <u>204 Poplar Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Charles C. Stuart Sr</u> First Middle Last				4. DATE OF DEATH <u>December 2 1961</u> Month Day Year					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 4, 1892</u>		9. AGE (In years last birthday) <u>69</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self employed</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Proprietor of restaurant.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>District of Washington, Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>J. Harry Stuart</u>				14. MOTHER'S MAIDEN NAME <u>Suvilla Cornell</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>Yes WW-1</u>				16. SOCIAL SECURITY NO. <u>215-18-0133</u>				17. INFORMANT <u>Clin Rec VAH Baltimore Md - Ft Howard Div</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA</u> DUE TO (b) <u>CHRONIC EMPYEMA</u> (c) <u>ARTERIOSCLEROTIC HEART DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>DIABETES MELLITUS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)								INTERVAL BETWEEN ONSET AND DEATH <u>7 DAYS</u> <u>OLD</u> <u>OLD</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>October 20, 1961</u> to <u>Dec. 2, 1961</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Dec. 2, 1961</u> , and that death occurred <u>4:50 a.m.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Paul G. Koukoulas M.D.</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>12-2-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Paul G. Koukoulas M.D.</u>				22d. ADDRESS <u>VAH, Baltimore 18, Md.-Ft Howard Division</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-5-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Blight, Inc.</u>				25a. REC'D BY REGISTRAR <u>DEC 5 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of informant		11. Signature of witness		12. Signature of funeral director	
13. Signature of coroner		14. Signature of medical examiner		15. Signature of health officer		16. Signature of state health officer	
17. Signature of state health officer		18. Signature of state health officer		19. Signature of state health officer		20. Signature of state health officer	
21. Signature of state health officer		22. Signature of state health officer		23. Signature of state health officer		24. Signature of state health officer	
25. Signature of state health officer		26. Signature of state health officer		27. Signature of state health officer		28. Signature of state health officer	
29. Signature of state health officer		30. Signature of state health officer		31. Signature of state health officer		32. Signature of state health officer	
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45. Signature of state health officer		46. Signature of state health officer		47. Signature of state health officer		48. Signature of state health officer	
49. Signature of state health officer		50. Signature of state health officer		51. Signature of state health officer		52. Signature of state health officer	
53. Signature of state health officer		54. Signature of state health officer		55. Signature of state health officer		56. Signature of state health officer	
57. Signature of state health officer		58. Signature of state health officer		59. Signature of state health officer		60. Signature of state health officer	
61. Signature of state health officer		62. Signature of state health officer		63. Signature of state health officer		64. Signature of state health officer	
65. Signature of state health officer		66. Signature of state health officer		67. Signature of state health officer		68. Signature of state health officer	
69. Signature of state health officer		70. Signature of state health officer		71. Signature of state health officer		72. Signature of state health officer	
73. Signature of state health officer		74. Signature of state health officer		75. Signature of state health officer		76. Signature of state health officer	
77. Signature of state health officer		78. Signature of state health officer		79. Signature of state health officer		80. Signature of state health officer	
81. Signature of state health officer		82. Signature of state health officer		83. Signature of state health officer		84. Signature of state health officer	
85. Signature of state health officer		86. Signature of state health officer		87. Signature of state health officer		88. Signature of state health officer	
89. Signature of state health officer		90. Signature of state health officer		91. Signature of state health officer		92. Signature of state health officer	
93. Signature of state health officer		94. Signature of state health officer		95. Signature of state health officer		96. Signature of state health officer	
97. Signature of state health officer		98. Signature of state health officer		99. Signature of state health officer		100. Signature of state health officer	

1 FOR STATE HEALTH DEPT. DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13695

MARYLAND STATE DEPARTMENT OF HEALTH MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13673

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b 8 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Res., 1921 Snyder Avenue				d. STREET ADDRESS 1921 Snyder Ave. 22, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CAROLYN MAY THOMAS				4. DATE OF DEATH Month Day Year December 6, 19 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 22, 1926	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bench Hand		10b. KIND OF BUSINESS OR INDUSTRY Western Electric		11. BIRTHPLACE (State or foreign country) Greenbank West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Sheets				14. MOTHER'S MAIDEN NAME Mamie Wilfong			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 235-38-6132		17. INFORMANT William Thomas 1921 Snyder Ave. 22, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot Wound of Head DUE TO (b) 776X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 1 Sec PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE JACK COLLINS, M.D. DATE SIGNED 12-6-61 EXAMINER'S NAME (Type) JACK COLLINS, M.D. Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-9-1961		22c. NAME OF CEMETERY OR CREMATORY Arbovale Cemetery		22d. LOCATION (City, town, or county) (State) Pocahontas Co. West Virginia	
23. FUNERAL DIRECTOR Wallace & Wallace Lewishburg, W. Virginia				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Arthur L. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death. Page 4 must be retained by the hospital or attending physician. 1. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13696

CERTIFICATE OF DEATH

13674

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Howard c. LENGTH OF STAY IN 1b 82 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 16 d. STREET ADDRESS 3331 Gwynns Falls Parkway e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LEROY N. THOMAS		4. DATE OF DEATH Month December Day 6 Year 1961	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 7, 1910
9. AGE (In years last birthday) 50 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Longshoreman	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James A. Thomas		14. MOTHER'S MAIDEN NAME Mamie Johnson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 220-05-5630	
17. INFORMANT Clinical Records, VAH, Baltimore 18, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF STOMACH WITH METASTASES 151X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PERITONITIS DUE TO (a) DUE TO (b) PERITONITIS DUE TO (a) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) UNKNOWN	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from September 15, 1961 , to December 6, 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on December 6, 1961 , and that death occurred at P. M., from the causes and on the date stated above.			
22a. SIGNATURE SEBASTIAN RUSSO, M.D.		22b. DATE 12/7/61	
22c. PHYSICIAN'S NAME SEBASTIAN RUSSO, M.D.		22d. ADDRESS VAH, BALTO 18 MD FT HOWARD Division	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-11-61	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCATION (City, town or county) (State) Baltimore 28, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Elroy O. Wilson		25a. REC'D BY REGISTRAR DEC 13 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Howard			

46892



1941

1940

1939

1938

1937

RECEIVED

RECEIVED

12-11-41

1100 Broadway Ave., Boston, Mass.

CERTIFICATE OF DEATH

Reg. Dist. No. 13675

13697

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK		c. LENGTH OF STAY IN 1b X DUNDALK	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2913 DUNDALK AVE.		d. STREET ADDRESS 2913 DUNDALK AVE.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First NETTIE Middle ETHEL Last TOWSON		4. DATE OF DEATH Month DEC. Day 3 Year 1961	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 7, 1885
9. AGE (In years lost birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JAMES ALEXIOUS HOVIS		14. MOTHER'S MAIDEN NAME MARTHA FOSTER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. INFORMANT Address DR. D.H. TOWSON 2907 DUNDALK AVE	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Influenza 481X Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) A-S-C-V-Renal Disease (c) Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH 10 days 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 24 , 19 61 , to Dec. 3 , 19 61 , that I last saw the deceased alive on Dec. 3 , 19 61 , and that death occurred at 5:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE M.B. Davis		ADDRESS (Street, city or town, state) 6800 Monmouth Road	
PHYSICIAN'S NAME (Type) M.B. DAVIS M.D.		DATE SIGNED Dec 12/5/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 12-6-61	
22c. NAME OF CEMETERY OR CREMATORY PARKWOOD CEM.		22d. LOCATION (City, town, or county) (State) BALTO. COUNTY MD.	
23. FUNERAL DIRECTOR'S SIGNATURE VLLRICH FUNERAL HOME		ADDRESS DUNDALK, MD.	
24a. REC'D BY REGISTRAR DATE DEC 8 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraw	

DECLARATION OF DEATH

107

(M)

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of declarant	
9. Signature of physician		10. Signature of medical examiner		11. Signature of coroner		12. Signature of registrar	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery		16. Signature of burial place	
17. Signature of interment place		18. Signature of crematorium		19. Signature of other place		20. Signature of other place	
21. Signature of other place		22. Signature of other place		23. Signature of other place		24. Signature of other place	
25. Signature of other place		26. Signature of other place		27. Signature of other place		28. Signature of other place	
29. Signature of other place		30. Signature of other place		31. Signature of other place		32. Signature of other place	
33. Signature of other place		34. Signature of other place		35. Signature of other place		36. Signature of other place	
37. Signature of other place		38. Signature of other place		39. Signature of other place		40. Signature of other place	
41. Signature of other place		42. Signature of other place		43. Signature of other place		44. Signature of other place	
45. Signature of other place		46. Signature of other place		47. Signature of other place		48. Signature of other place	
49. Signature of other place		50. Signature of other place		51. Signature of other place		52. Signature of other place	
53. Signature of other place		54. Signature of other place		55. Signature of other place		56. Signature of other place	
57. Signature of other place		58. Signature of other place		59. Signature of other place		60. Signature of other place	
61. Signature of other place		62. Signature of other place		63. Signature of other place		64. Signature of other place	
65. Signature of other place		66. Signature of other place		67. Signature of other place		68. Signature of other place	
69. Signature of other place		70. Signature of other place		71. Signature of other place		72. Signature of other place	
73. Signature of other place		74. Signature of other place		75. Signature of other place		76. Signature of other place	
77. Signature of other place		78. Signature of other place		79. Signature of other place		80. Signature of other place	
81. Signature of other place		82. Signature of other place		83. Signature of other place		84. Signature of other place	
85. Signature of other place		86. Signature of other place		87. Signature of other place		88. Signature of other place	
89. Signature of other place		90. Signature of other place		91. Signature of other place		92. Signature of other place	
93. Signature of other place		94. Signature of other place		95. Signature of other place		96. Signature of other place	
97. Signature of other place		98. Signature of other place		99. Signature of other place		100. Signature of other place	

13698

13670

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md.		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkridge	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1700 Levering Avenue		d. STREET ADDRESS 1700 Levering Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Sidney Travers		4. DATE OF DEATH Dec. 24, 1961		5. SEX male	
6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 2, 1888	
9. AGE (In years last birthday) 73 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baltimore Water Dept.-Retired		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME John H. Travers		14. MOTHER'S MAIDEN NAME Catherine J. Sheet	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Ada V. Travers, 1700 Levering Avenue	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO (b) chron Myocarditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) General arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 3 mo		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Baltimore		20g. (County) Baltimore		20h. (State) Md.	
21. I certify that (I) (this hospital) attended the deceased from Dec 17, 1961 to Dec 24, 1961 , that (I) (we) last saw the deceased alive on Dec 24, 1961 , and that death occurred at 3:30 P.M. from the causes and on the date stated above.					
22a. SIGNATURE B. B. Brumbaugh M.D.		22b. DATE 12/27/61		22c. PHYSICIAN'S NAME (Type) Bruce B. Brumbaugh, M.D.	
22d. ADDRESS 5609 Main Street Elkridge Md		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. DATE 12/27/61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/27/61		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	
23d. LOCATION (City, town or county) Baltimore, Maryland		23e. (State) Md.		23f. REC'D BY REGISTRAR DEC 29 '61	
23g. REGISTRAR'S SIGNATURE Clara L. Travis		23h. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		23i. ADDRESS 4107 Wilkens Avenue	



1938

Bel. Moore

Int. Soc.

1700 Levee Avenue

1700 Levee Avenue

John

John

Traverse

Dec. 2, 1938

of

male

white

Nov. 2, 1938

Baltimore, Md. - Bel. Moore

Levee

John H. Traverse

Catherine J. Sheer

no

Adm. W. Traverse, 1700 Levee Avenue

[Faint, illegible handwritten notes]

[Faint, illegible handwritten notes]

12/27/61 - London Park Cemetery, Baltimore, Md. - Int.

Howard H. Hubbard 1101 Wilkins Avenue

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13699

Item 11 Film G305 1/8/62 mh

13677

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) PIKESVILLE c. LENGTH OF STAY in 1b 10 Yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Orchard Road				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pikesville d. STREET ADDRESS Orchard Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Edward Benedict Tucker				4. DATE OF DEATH 12-31-61 Month Day Year December 31, 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 18, 1907 yrs. 54	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chaffuer, Gas & Electric Co.				10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (County & State, or foreign country) U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 212-10-5973		17. INFORMANT Mrs. Thelma E. Tucker, (Wife) Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO Coronary Sclerosis (b) 3 months (c)				INTERVAL BETWEEN ONSET AND DEATH 15 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 1961 to Dec 31, 1961 , that (I) (we) last saw the deceased alive on Dec 19, 1961 , and that death occurred at 7:45 A.M. from the causes and on the date stated above.							
22a. SIGNATURE James A. Miller M.D.				22b. DATE SIGNED Jan. 2, 1962		22c. ADDRESS 1331 Reisterstown Rd Pikesville - Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-3-1962		23c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial		23d. LOCATION (City, town or county) (State) Finksberg, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell, Pikesville, Md.				25a. REC'D BY REGISTRAR Jan 3 '62		25b. REGISTRAR'S SIGNATURE Arthur L. Thomas	



52

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
13700		Items 8 & 9 Film G305 1/10/62 iwk				13678			
1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pikesville		c. LENGTH OF STAY IN 1b 1- 1/2 Yrs		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4720 Duncannon Rd.				d. STREET ADDRESS 4720 Duncannon Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Joan Clair Underwood		3. NAME OF DECEASED (Type or print) Joan Clair Underwood		4. DATE OF DEATH Month 12-29 Day 19 Year 61					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-17-1931		9. AGE (In years last birthday) 30	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secty. General Electric Co.		10b. KIND OF BUSINESS OR INDUSTRY Pittsburgh Pa.		11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William J. Fogarty				14. MOTHER'S MAIDEN NAME Bessie I. Facto					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes give year or dates of service)		17. INFORMANT Charles William Underwood, (Husband)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Viral Pneumonia DUE TO Asphyxiation Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO Diabetes Mellitus								INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on....., 19....., and that death occurred at.....M, from the causes and on the date stated above.									
22a. SIGNATURE S. Kaplan				22b. DATE SIGNED 12-29-61					
22c. PHYSICIAN'S NAME (Type) S. Kaplan				22d. ADDRESS Pittsburgh Pa.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-3-1962		23c. NAME OF CEMETERY OR CREMATORY ST. Bernard's		23d. LOCATION (City, town or county) (State) Fitchburg, Mass.			
24. FUNERAL DIRECTOR'S SIGNATURE Frank H. Newell, Pikesville 8 Md				25a. REC'D BY REGISTRAR JAN 2 '62		25b. REGISTRAR'S SIGNATURE Arthur J. Thomas			

13278

13278



720 Thompson St.

720 Thompson St.

11-30 Underwood

11-30

U.S.A.

U.S.A.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13701

13679

1. PLACE OF DEATH a. COUNTY <div style="text-align: center; font-size: 1.2em;">Baltimore</div> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <div style="text-align: center; font-size: 1.2em;">Owings Mills</div> c. LENGTH OF STAY IN lb <div style="text-align: center; font-size: 1.2em;">27 years</div> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <div style="text-align: center; font-size: 1.2em;">Walk Avenue</div>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <div style="text-align: center; font-size: 1.2em;">Maryland</div> b. COUNTY <div style="text-align: center; font-size: 1.2em;">Baltimore</div> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <div style="text-align: center; font-size: 1.2em;">Owings Mills</div> d. STREET ADDRESS <div style="text-align: center; font-size: 1.2em;">Walk Avenue</div> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <div style="text-align: center; font-size: 1.2em;">Elizabeth</div>				4. DATE OF DEATH Month Day Year <div style="text-align: center; font-size: 1.2em;">Dec. 31, 19 61</div>															
5. SEX <div style="text-align: center; font-size: 1.2em;">Female</div>		6. COLOR OR RACE <div style="text-align: center; font-size: 1.2em;">White</div>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>															
8. DATE OF BIRTH <div style="text-align: center; font-size: 1.2em;">Jan. 10, 1888</div>		9. AGE (In years last birthday) <div style="text-align: center; font-size: 1.2em;">73 yrs.</div>		IF UNDER 1 YEAR Months Days Hours Min.															
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <div style="text-align: center; font-size: 1.2em;">Housewife</div>				10b. KIND OF BUSINESS OR INDUSTRY 															
11. BIRTHPLACE (County & State, or foreign country) <div style="text-align: center; font-size: 1.2em;">Austria</div>				12. CITIZEN OF WHAT COUNTRY? <div style="text-align: center; font-size: 1.2em;">U.S.A.</div>															
13. FATHER'S NAME <div style="text-align: center; font-size: 1.2em;">John Noll</div>				14. MOTHER'S MAIDEN NAME <div style="text-align: center; font-size: 1.2em;">Anna Schobel</div>															
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <div style="text-align: center; font-size: 1.2em;">No</div>		16. SOCIAL SECURITY NO. <div style="text-align: center; font-size: 1.2em;">None</div>		17. INFORMANT Address <div style="text-align: center; font-size: 1.2em;">Mr. John Walk 6 Byway, Owings Mills, Md.</div>															
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <table style="width: 100%;"> <tr> <td colspan="2"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <div style="font-size: 1.5em;">434</div> </td> <td colspan="2"> DUE TO <div style="font-size: 1.5em;">Coronary Thrombosis - acute</div> </td> <td colspan="2" rowspan="3"> INTERVAL BETWEEN ONSET AND DEATH <div style="font-size: 1.5em;">Minutes</div> </td> </tr> <tr> <td colspan="2"> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. </td> <td colspan="2"> (b) <div style="font-size: 1.5em;">Congestive Heart Failure - chronic</div> </td> </tr> <tr> <td colspan="2"></td> <td colspan="2"> (c) </td> </tr> </table>						PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <div style="font-size: 1.5em;">434</div>		DUE TO <div style="font-size: 1.5em;">Coronary Thrombosis - acute</div>		INTERVAL BETWEEN ONSET AND DEATH <div style="font-size: 1.5em;">Minutes</div>		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) <div style="font-size: 1.5em;">Congestive Heart Failure - chronic</div>				(c) 	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <div style="font-size: 1.5em;">434</div>		DUE TO <div style="font-size: 1.5em;">Coronary Thrombosis - acute</div>		INTERVAL BETWEEN ONSET AND DEATH <div style="font-size: 1.5em;">Minutes</div>															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) <div style="font-size: 1.5em;">Congestive Heart Failure - chronic</div>																	
		(c) 																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <div style="text-align: center; font-size: 1.2em;">19</div>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 															
20f. (City or town) 		(County) 		(State) 															
21. I certify that (I) (this hospital) attended the deceased from <div style="font-size: 1.2em;">July 1954</div> to <div style="font-size: 1.2em;">December 31, 1961</div> that (I) (we) last saw the deceased alive on <div style="font-size: 1.2em;">December 31, 1961</div> and that death occurred at <div style="font-size: 1.2em;">3:00 PM</div> from the causes and on the date stated above.																			
22. SIGNATURE <div style="font-size: 1.5em;">Clarence E. McWilliams</div> M.D. 22c. PHYSICIAN'S NAME (Type) <div style="font-size: 1.2em;">Clarence E. McWilliams M.D.</div>				22b. DATE SIGNED <div style="font-size: 1.2em;">December 31, 1961</div>															
22d. ADDRESS <div style="font-size: 1.2em;">11904 Reisterstown Rd Reisterstown Maryland</div>																			
23a. BURIAL, CREMATION, REMOVAL (Specify) <div style="text-align: center; font-size: 1.2em;">Burial</div>		23b. DATE THEREOF <div style="text-align: center; font-size: 1.2em;">Jan. 3, 1962</div>		23c. NAME OF CEMETERY OR CREMATORY <div style="text-align: center; font-size: 1.2em;">Holy Cross Cemetery</div>															
23d. LOCATION (City, town or county) <div style="text-align: center; font-size: 1.2em;">Baltimore, Maryland</div>																			
24. FUNERAL DIRECTOR'S SIGNATURE <div style="font-size: 1.5em;">Henry James Eckhardt</div> ADDRESS <div style="text-align: center; font-size: 1.2em;">Owings Mills, Md.</div>				25a. REC'D BY REGISTRAR <div style="text-align: center; font-size: 1.2em;">JAN 2 '62</div>															
				25b. REGISTRAR'S SIGNATURE <div style="font-size: 1.2em;">Arthur S. Kraus</div>															

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13680

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kingsville</u>		c. LENGTH OF STAY IN 1b <u>19 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Box 679, Belair Rd</u>		d. STREET ADDRESS <u>Belair Rd</u>	
3. NAME OF DECEASED (Type or print) <u>JAMES WALKER</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>3</u> Year <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/11/85</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shipping Clk.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sen'l Elect</u>	
11. BIRTHPLACE (State or foreign country) <u>Scotland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNK.</u>		14. MOTHER'S MAIDEN NAME <u>UNK.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>321 057189</u>	
17. INFORMANT <u>George Bothoff</u> Address <u>Box 679 Kingsville</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Degeneration</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Arty disease c occlus.</u> (c) <u>Arteriosclerosis</u></p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Known to drink heavily at times</u></p> </div> <div style="width: 15%;"> <p>INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u></p> </div> </div>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank T. Kasink</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK T KASINK JR</u>		DATE SIGNED <u>12/3/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-8-1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT Emblem Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Chicago Ill.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassala Funeral Home</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 6 '61</u>	
ADDRESS <u>7401 Belair Road</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Francis</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH



Form with multiple sections for medical examination and death certification, including fields for name, date, time, and cause of death. The form is oriented horizontally but contains vertical text labels for various fields.

NAME: [illegible]
DATE: [illegible]
TIME: [illegible]
PLACE: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE: [illegible]
OFFICIAL SEAL: [illegible]

CERTIFICATE OF DEATH

Reg. Dist. No. **13681****13703**

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3604 North Chapman Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ida Middle Rosilia Last Ware				4. DATE OF DEATH Month Dec. Day 26 Year 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 3, 1912		9. AGE (In years last birthday) 49 yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	IF UNDER 24 HRS. Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hairdresser		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Howard Worthington Young				14. MOTHER'S MAIDEN NAME Rosilia Tarr			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-18-3688		INFORMANT Address James M. Ware 3604 North Chapman Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Acute Myocardial Infarct DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (c)							INTERVAL BETWEEN ONSET AND DEATH 2 hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. — p. m. — 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 19 61 , to Dec. 26 , 19 61 , that I last saw the deceased alive on Dec. 26 , 19 61 , and that death occurred at 6:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE M. J. Ellison				ADDRESS (Street, city or town, state) 8627 Liberty Rd. Randallstown, Md.		DATE SIGNED 4/27/61	
PHYSICIAN'S NAME (Type) M. J. Ellison							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 29, 1961		22c. NAME OF CEMETERY OR CREMATORY Mount Olive Cemetery		22d. LOCATION (City, town, or county) (State) Randallstown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost				24a. REC'D BY REGISTRAR DATE DEC 27 '61		24b. REGISTRAR'S SIGNATURE W. S. Thomas	
25. ADDRESS Ellsworth Armacost 4600 Liberty Heights Ave.							

Page 4

TO HOSPITAL OR A PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, or in any event within 72 hours after death.

CERTIFICATE OF DEATH

19703

1. Name of Deceased: _____

2. Sex: _____

3. Date of Birth: _____

4. Place of Birth: _____

5. Date of Death: _____

6. Time of Death: _____

7. Cause of Death: _____

8. Place of Death: _____

9. Signature of Physician: _____

10. Signature of Registrar: _____

11. Date of Registration: _____

12. Name of Registrar: _____

13. Name of Hospital: _____

14. Name of Doctor: _____

15. Name of Nurse: _____

16. Name of Assistant: _____

17. Name of Attendant: _____

18. Name of Burial Place: _____

19. Name of Burial: _____

20. Name of Interment: _____

21. Name of Cemetery: _____

22. Name of Church: _____

23. Name of Minister: _____

24. Name of Pastor: _____

25. Name of Rector: _____

26. Name of Vicar: _____

27. Name of Chaplain: _____

28. Name of Priest: _____

29. Name of Monk: _____

30. Name of Nun: _____

31. Name of Friar: _____

32. Name of Brother: _____

33. Name of Sister: _____

34. Name of Mother: _____

35. Name of Father: _____

36. Name of Grandfather: _____

37. Name of Grandmother: _____

38. Name of Uncle: _____

39. Name of Aunt: _____

40. Name of Cousin: _____

41. Name of Nephew: _____

42. Name of Niece: _____

43. Name of Son: _____

44. Name of Daughter: _____

45. Name of Wife: _____

46. Name of Husband: _____

47. Name of Partner: _____

48. Name of Friend: _____

49. Name of Neighbor: _____

50. Name of Stranger: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY in lb 271 days		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital						d. STREET ADDRESS 1713 De Sota Road - 30					
3. NAME OF DECEASED (Type or print) JOHN J. WATSON		4. DATE OF DEATH Dec. 17 1961		5. SEX Male		6. COLOR OR RACE White		7. MARIED <input type="checkbox"/> NEVER MARIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/30/1900	
9. AGE (In years last birthday) 61 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sewing Machine Operator		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joseph Watson		14. MOTHER'S MAIDEN NAME Nellie Victor	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-11 216-09-6543		17. INFORMANT Clinical Records, VA Hospital Baltimore, Maryland-FORT HOWARD DIVISION		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF HYPOPHARYNX WITH METASTASIS TO LUNGS, AND LYMPH NODES Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DOES NOT EXIST DUE TO (c) 147 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 147		INTERVAL BETWEEN ONSET AND DEATH 14 months		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore		20g. (County) Baltimore		20h. (State) Maryland	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 21 1961 to Dec. 17 1961 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Dec. 17 1961 , and that death occurred at 2 p.m. M, from the causes and on the date stated above.											
22a. SIGNATURE John D. Talbert, M.D.		22b. DATE SIGNED 12/18/61		22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M.D. Med. Serv. VAH Baltimore, Md - Fort Howard Division		22d. ADDRESS 637 Washington Blvd Baltimore, Md.		22e. REC'D BY REGISTRAR DEC 22 '61		22f. REGISTRAR'S SIGNATURE Charles S. Kinner	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 21, 1961		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCATION (City, town or county) Baltimore		23e. (State) Maryland		23f. FUNERAL DIRECTOR'S SIGNATURE KACHAUSKAS FUNERAL HOME	

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Veterans Administration Hospital

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Wiltshire

Male

Sewing Machine Operator, John's Tailor Factory, Baltimore, Maryland, U.S.A.

In the Vision

John's Vision

Division, Baltimore, Maryland - 1001 Howard Division

1940-00-0000

Wiltshire

Male

CONCERN OF HYPOTHESIS WITH REFERENCE TO MINDS
AND EARTH HOUSE

1940-00-0000

1940-00-0000

Act. Chief

JOHN D. TAYLOR, M.D., 1001 Howard Division, Baltimore, Maryland

Baltimore (National) Cemetery

1713 de 8012 1001 - 30

Baltimore (National) Cemetery

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. Page 5 must be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MEDICAL CERTIFICATION

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13706

13684

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>				c. LENGTH OF STAY IN 1b <u>13 years</u> X <u>Reisterstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sten Halls Rd</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALBERT THEODORE WELVAERT</u>				4. DATE OF DEATH Month Day Year <u>December 30 1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 23, 1901</u>	9. AGE (In years last birthday) <u>60</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Operating Dog Kennel</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Belgium</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Julian Joseph Welvaert</u>				14. MOTHER'S MAIDEN NAME <u>Celine Reiss</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, list war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>152-16-8980</u>		17. INFORMANT Address <u>Mrs. Zena Welvaert Sten Halls Rd Reisterstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive Heart Failure - Chronic</u> DUE TO (c) <u>9 hours</u> INTERVAL BETWEEN ONSET AND DEATH <u>9 hours</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>February 1961</u> to <u>December 30, 1961</u> , that (I) (we) last saw the deceased alive on <u>December 29, 1961</u> , and that death occurred at <u>4:15 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Clarence E. McWilliams</u> M.D.				22b. DATE SIGNED <u>December 30, 1961</u>		22c. PHYSICIAN'S NAME (Type) <u>11904 Reisterstown Rd Reisterstown, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 2, 1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>All Saints Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Reisterstown, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>J. F. Eline & Sons Reisterstown, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>JAN 2 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CENTRAL FILE DIVISION

10705



TO HOSPITAL OR A BOARDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13707

13685

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) English Counsel				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) English Counsel			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4420 Walnut Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) (JohnFred) Henry First John Middle Wenger Last				4. DATE OF DEATH Month 12/20/61 Day 19 Year			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 26, 1879		9. AGE (In years lost birthday) 82 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.		10b. KIND OF BUSINESS OR INDUSTRY West. Md. RR		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John F. Wenger				14. MOTHER'S MAIDEN NAME Frances Walberger			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Family		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Accident - 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Hemorrhage - DUE TO (c) Diabetes Mellitus -						INTERVAL BETWEEN ONSET AND DEATH 1 day 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 10, 1961 to Dec 20, 1961 , that (I) (we) last saw the deceased alive on Dec 19, 1961 , and that death occurred at 6 M. from the causes and on the date stated above.							
22a. SIGNATURE Paul Schanfeld				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/20/61	
22c. PHYSICIAN'S NAME (Type) Paul Schanfeld				22d. ADDRESS 2301 Annapolis Rd			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/23/61		23c. NAME OF CEMETERY OR CREMATORY Holy Cross		23d. LOCATION (City, town, or county) (State) Balto, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Homes 130 E. Fort Ave. # 30				25a. REC'D BY REGISTRAR DATE DEC 21 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. 1. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
13708											
13686											
1. PLACE OF DEATH a. COUNTY BALTO. MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MD. b. COUNTY —					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE						c. LENGTH OF STAY IN 1b 3Y01.4					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SUMMIT NURSING HOME						d. STREET ADDRESS 4606 MANORDENE RD.					
3. NAME OF DECEASED (Type or print) First HENRY Middle WESS Last WESS						4. DATE OF DEATH Month DEC. Day 9 Year 1961					
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LIEUT.-RET. FIRE DEPT.						10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) U. S. A.	
13. FATHER'S NAME BERNARD WESS						14. MOTHER'S MAIDEN NAME NOT KNOWN					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO						16. SOCIAL SECURITY NO.					
17. INFORMANT Charles Wess - 237 E. Medwick North						Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) ATHERO SCLEROSIS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS						INTERVAL BETWEEN ONSET AND DEATH 1 HOUR					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Balto.		20g. (County) MD.		20h. (State) MD.	
21. I certify that (I) (this hospital) attended the deceased from July 12/7/59 , 19 57 to 12/9/61 , 19 61 , that (I) (we) last saw the deceased alive on 12/7/61 , 19 61 , and that death occurred at 7 AM , from the causes and on the date stated above.											
22a. SIGNATURE Herbert W. Lapp						22b. DATE SIGNED 12/11/61		22c. PHYSICIAN'S NAME (Type) HERBERT W LAPP			
22d. ADDRESS 4804 FREDERICK AVE. 19						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-13-61		23c. NAME OF CEMETERY OR CREMATORY St. Peters Cem.		23d. LOCATION (City, town or county) Balto.		23e. (State) MD.		23f. (Country)	
24. FUNERAL DIRECTOR'S SIGNATURE Foley-Cunning B.F.H. - Catonsville, Md.						24a. ADDRESS		25a. REC'D BY REGISTRAR DEC 13 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	



RECEIVED

1. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. 1. FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13687

13709

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Balto.			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Glyndon				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) X Glyndon			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 5 Fisk Ave.				d. STREET ADDRESS 5 Fisk Ave.			
3. NAME OF DECEASED (Type or print) Lester Sollers Wheeler				4. DATE OF DEATH Month Dec. Day 17, Year 19 61			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 7, 1888		9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baltimore County			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Edward G. Wheeler			14. MOTHER'S MAIDEN NAME Mary Griffith				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 212-30-8541		17. INFORMANT Mrs. Elizabeth M. Wheeler Address Glyndon, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic C-V Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Ca. of Prostate						INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) none					
20c. TIME OF INJURY Month, Day, Year Hour a.m. none p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> none		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (XXXXXX) attended the deceased from 1-22-37 to 12-17-61 , 19 61 , that (I) (XX) saw the deceased alive on 12-16-61 , 19 61 , and that death occurred at 12:30 M, from the causes and on the date stated above.							
22a. SIGNATURE D. D. Caples				22b. DATE 12-18-61		22c. PHYSICIAN'S NAME (Type) D. D. Caples, M. D.	
22d. ADDRESS 6 Hanover Rd., Reisterstown, Md.				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 20, 1961		23c. NAME OF CEMETERY OR CREMATORY Dover Cemetery		23d. LOCATION (City, town or county) (State) Glyndon, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. F. Eline & Sons				ADDRESS Reisterstown, Md.		25a. REC'D BY REGISTRAR DATE DEC 22 '61	
				25b. REGISTRAR'S SIGNATURE Anthony S. Thomas			

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Co. of Troops

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13710

13688

1. PLACE OF DEATH a. COUNTY Baltimore Co. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Owings Mills		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Owings Mills	
c. LENGTH OF STAY IN TB 5 years		d. STREET ADDRESS Deer Park Rd.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Deer Park Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Sweet David Whittington		4. DATE OF DEATH Dec. 1 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 5, 1867
9a. AGE (In years last birthday) 94 yrs.		9b. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith		10b. KIND OF BUSINESS OR INDUSTRY Own Business	
11. BIRTHPLACE (County & State, or foreign country) West Va.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME James C. Whittington		14. MOTHER'S MAIDEN NAME Ruth H Morningstar	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Mrs Maggie Whittington		Address Deer Park Rd. Owings Mills, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, lobar bilateral DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO ASCVB PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from Jan. 4 , 19 61 , to Dec. 1 , 19 61 , that (1) (we) last saw the deceased alive on Nov 30 , 19 61 , and that death occurred at 5 A.M. , from the causes and on the date stated above.			
22a. SIGNATURE John J. Darrell M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) John J. Darrell M.D.		22d. ADDRESS 9017 Liberty Rd. Randallstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 4, 1961	
23c. NAME OF CEMETERY OR CREMATORY Edge Hill Cemetery		23d. LOCATION (City, town or county) (State) Charlestown W. Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Loring Byers ADDRESS 8728 Liberty Road Randallstown, Md.		25a. REC'D BY REGISTRAR DATE DEC 4 '61	
25b. REGISTRAR'S SIGNATURE Arthur B. Hines			

(M)

(A)

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **13689**

13711

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SPARKS		c. LENGTH OF STAY IN 1b NINE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SPARKS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Quaker Bottom RD.				d. STREET ADDRESS Quaker Bottom RD.			
3. NAME OF DECEASED (Type or print) First Middle Last HARRISON Chesterfield Whye				4. DATE OF DEATH Month Day Year dec 3 1961			
5. SEX M	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 17. 1899		9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER (RETIRED)		10b. KIND OF BUSINESS OR INDUSTRY unl.		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME CLINTON Whye				14. MOTHER'S MAIDEN NAME SUSANNA MARTIN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 312-16-3571		17. INFORMANT Address BERTHA Whye - PARKTON, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE A. M. France M.D.				DATE SIGNED 12/4/61			
EXAMINER'S NAME (Type) P. M. FRANCE				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/6/61		22c. NAME OF CEMETERY OR CREMATORY St. Lukes		22d. LOCATION (City, town, or county) (State) Chesford Batts. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. L. Chaturman				24a. REC'D BY REGISTRAR DEC 6 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kiser	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G302 12/18/61 iwk

13712

CERTIFICATE OF DEATH

Reg. Dist. No. 13690

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>		c. LENGTH OF STAY IN 1b <u>22 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>B. 160 Bird River Road</u>				d. STREET ADDRESS <u>1 B. 160 Bird River Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Philip</u> Middle <u>R</u> Last <u>Wich</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>11</u> Year <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>8-20-1892</u>		9. AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>General Maintenance</u>		11. BIRTHPLACE (State or foreign country) <u>Manchester England</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ferdinand Wich</u>				14. MOTHER'S MAIDEN NAME <u>Emma Faulkner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>WW1</u> (If yes, give war or dates of service) <u>Army</u>		16. SOCIAL SECURITY NO. <u>216-09-5062A</u>		INFORMANT <u>Mrs Rebecca A Wich</u> Address <u>Box 160 Bird River Road (20)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Cerebral arteriosclerosis</u> DUE TO (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u>Coronary insufficiency</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>5 yrs</u> <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u> </u> <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-2</u> , 19 <u>59</u> , to <u>12-11</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>12-1</u> , 19 <u>61</u> , and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Leopoldo Gross</u> M.D.				ADDRESS (Street, city or town, state)		DATE SIGNED <u>12-11-61</u>	
PHYSICIAN'S NAME (Type) <u>405 Stemmers Run Rd Baltimore 21 Md</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-14-1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GARDENS OF FAITH Cem</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leopoldo Gross</u>				ADDRESS <u>7461 Belair Road</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	
				24a. REC'D BY REGISTRAR <u>DEC 14 '61</u>			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13713

Item 1a, Film G305 1/5/62 iwk

Reg. Dist. No. 13691

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb 17 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print) First Dora Middle May Last Williams		d. STREET ADDRESS Formerly 1613 North Hilton St.	
4. DATE OF DEATH Month Dec Day 30 Year 1961		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 1, 1876
9. AGE (In years last birthday) 85 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	
11. BIRTHPLACE (State or foreign country) Maryland-Baltimore		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Francis Asbury Smith		14. MOTHER'S MAIDEN NAME Sarah Barker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) terminal pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (b) ra chexia (c) malignancy of GI tract DUE TO couse lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arteriosclerosis, generalized 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 2 days one year one year	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> 159X		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) On 12-20-61 pt. fell out of bed striking right side of face and causing a large swollen area	
20c. TIME OF INJURY Month, Day, Year 12-20-61 Hour 4:10 o. m. <input type="checkbox"/> p. m. <input checked="" type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) hospital	
20e. (City or town) Catonsville 28, Maryland		20f. (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Joseph R. Gladue		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Joseph R. Gladue, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-2-62	
22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Adams		24a. REC'D BY REGISTRAR DATE JAN 3 '62	
ADDRESS Balt. 12, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be written the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. If the certificate is not to be used, it should be returned to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10-13

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		MILITARY SERVICE		MILITARY SERVICE		MILITARY SERVICE		MILITARY SERVICE		MILITARY SERVICE		MILITARY SERVICE		MILITARY SERVICE		MILITARY SERVICE		MILITARY SERVICE		MILITARY SERVICE	
CAUSE OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH	
SIGNATURE OF MEDICAL EXAMINER		DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY		CITY		STATE		COUNTRY		CITY	

10-13

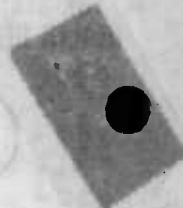
FOR STATE HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. The certificate should be executed by the Deputy Medical Examiner, or his designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. The certificate should be executed by the Deputy Medical Examiner, or his designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. The certificate should be executed by the Deputy Medical Examiner, or his designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div> <div> <div>1-18-62</div> <div>305</div> </div> <div> <div>Item 1 Film G307</div> <div>12/20/61</div> </div> </div> <div> <div>Item 18-62</div> <div>305</div> </div> <div> <div>Item 1 Film G307</div> <div>12/20/61</div> </div>											
<div> <div> <div>1. PLACE OF DEATH</div> <div> <div>a. COUNTY</div> <div>Baltimore</div> </div> </div> <div> <div>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</div> <div>Baltimore</div> </div> </div> <div> <div>c. LENGTH OF STAY IN 1b</div> <div>Baltimore</div> </div>											
<div> <div> <div>2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission)</div> <div> <div>a. STATE</div> <div>Maryland</div> </div> </div> <div> <div>b. COUNTY</div> <div>Baltimore Co.</div> </div> </div> <div> <div>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</div> <div>Baltimore County</div> </div> <div> <div>d. STREET ADDRESS</div> <div>5535 Frederick Road</div> </div> <div> <div>e. IS RESIDENCE ON A FARM?</div> <div>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></div> </div>											
<div> <div> <div>3. NAME OF DECEASED (Type or print)</div> <div>First</div> <div>ROY</div> <div>Middle</div> <div>Emmett</div> <div>Last</div> <div>WILSON</div> </div> <div> <div>4. DATE OF DEATH</div> <div>December 18, 19 61</div> </div> </div>											
<div> <div>5. SEX</div> <div>Male</div> </div> <div> <div>6. COLOR OR RACE</div> <div>White</div> </div> <div> <div>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/></div> <div>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></div> </div> <div> <div>8. DATE OF BIRTH</div> <div>48 yrs.</div> </div> <div> <div>9. AGE (In years last birthday)</div> <div>48 yrs.</div> </div> <div> <div>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div> <div>Steel Worker</div> </div> <div> <div>11. BIRTHPLACE (State or foreign country)</div> <div>GALAX, Virginia</div> </div> <div> <div>12. CITIZEN OF WHAT COUNTRY?</div> <div></div> </div>											
<div> <div>13. FATHER'S NAME</div> <div>ALONZA D. WILSON</div> </div> <div> <div>14. MOTHER'S MAIDEN NAME</div> <div>FLOKA CARPENTER</div> </div> <div> <div>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)</div> <div>NO</div> </div> <div> <div>16. SOCIAL SECURITY NO.</div> <div>223-12-0713</div> </div> <div> <div>17. INFORMANT</div> <div>Delmer Wilson, (Brother)</div> </div>											
<div> <div>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</div> <div> <div>PART I. DEATH WAS CAUSED BY:</div> <div> <div>IMMEDIATE CAUSE (a)</div> <div>Batty Metamorphosis of Liver</div> </div> <div> <div>322.0</div> <div>DUE TO</div> <div>Alcoholism, Acute and Chronic</div> </div> <div> <div>Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.</div> <div>DUE TO</div> </div> </div> <div> <div>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)</div> <div></div> </div> </div> <div> <div>19. WAS AUTOPSY PERFORMED?</div> <div>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></div> </div>											
<div> <div>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</div> <div>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</div> </div>											
<div> <div>20c. TIME OF INJURY</div> <div>Month, Day, Year</div> <div>Hour e.m. p.m.</div> <div>19</div> </div> <div> <div>20d. INJURY OCCURRED</div> <div>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></div> </div> <div> <div>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</div> <div></div> </div> <div> <div>20f. (City or town)</div> <div></div> </div> <div> <div>(County)</div> <div></div> </div> <div> <div>(State)</div> <div></div> </div>											
<div> <div>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from:</div> <div> <div>Natural causes <input checked="" type="checkbox"/></div> <div>Accident <input type="checkbox"/></div> <div>Suicide <input type="checkbox"/></div> <div>Homicide <input type="checkbox"/></div> <div>Undetermined manner <input type="checkbox"/></div> </div> <div> <div>CHIEF MEDICAL EXAMINER</div> <div>HOWARD G. SHAUB, M. D.</div> </div> <div> <div>ASSISTANT MEDICAL EXAMINER</div> <div></div> </div> <div> <div>DEPUTY MEDICAL EXAMINER</div> <div></div> </div> <div> <div>DATE SIGNED</div> <div>December 19, 1961</div> </div> </div>											
<div> <div>22a. BURIAL, CREMATION, REMOVAL (Specify)</div> <div>Removed (Burial)</div> </div> <div> <div>22b. DATE THEREOF</div> <div>12-20-61</div> </div> <div> <div>22c. NAME OF CEMETERY OR CREMATORY</div> <div>DAKLAND Cemetery</div> </div> <div> <div>22d. LOCATION (City, town, or country) (State)</div> <div>GALAX, CARROLL CO., VA.</div> </div>											
<div> <div>23. FUNERAL DIRECTOR</div> <div>Wm. Cook-Blight, Inc., 6009 Harford Road, Baltimore, Md.</div> </div> <div> <div>24a. REC'D BY REGISTRAR</div> <div>DEC 22 '61</div> </div> <div> <div>24b. REGISTRAR'S SIGNATURE</div> <div></div> </div>											



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completed and filed in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

13715

UNITED STATES DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13692

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 9mth13dys	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. MARYLAND PARK		d. STREET ADDRESS 1627-2 6514 Earley Street - N.E.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle M Last Wolf		4. DATE OF DEATH Month December Day 8 Year 1961	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-18-1890
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months 7 Days 18 Hours 18 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	
11. BIRTHPLACE (State or foreign country) CHICAGO Illinois		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal bronchopneumonia 355X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Malnutrition and dehydration DUE TO (c) Senile brain disease INTERVAL BETWEEN ONSET AND DEATH 5 days months years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from Feb. 21 1961 to Dec. 8 1961 that (I) (we) last saw the deceased alive on Dec. 8 1961 and that death occurred at p. 1:40 M, from the causes and on the date stated above.			
22a. SIGNATURE Stella Wachslar		22b. DATE SIGNED 12-8-61	
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M.D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Catonsville 28, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-12-61	
23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATH		23d. LOCATION (City, town, or county) (State) FT MYER VA	
24. FUNERAL DIRECTOR'S SIGNATURE W.W. Chambers Co		25a. REC'D BY REGISTRAR 517-11-54 SE WASH, DC	
25b. REGISTRAR'S SIGNATURE DEC 13 '61		25c. DATE	

10712

CERTIFICATE OF DEATH

1901



(M)

13713

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HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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M
X
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13717
CERTIFICATE OF DEATH
13694

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-White Hall</u>		c. LENGTH OF STAY IN 1b <u>75 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>White Hall Rd.</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-White Hall, Md.</u>	
3. NAME OF DECEASED (Type or print) <u>Tillie J. Wright</u>		4. DATE OF DEATH <u>Dec 3</u> 19 <u>61</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 21/1867</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (County & State, or foreign country) <u>York Co., Pa.</u>
13. FATHER'S NAME <u>James Trout</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic C.V.S. disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		17. INFORMANT <u>Mr. Raymond Thomas, White Hall Md.</u> Address <u>White Hall Md.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 2</u> , 19 <u>61</u> , to <u>Dec 3</u> , 19 <u>61</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>Dec. 2</u> , 19 <u>61</u> , and that death occurred at <u>7 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>A. M. France</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>		22d. ADDRESS <u>PATKTON, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>12-5-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>West Liberty Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>White Hall, Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartenstein, New Freedom, Pa.</u>		25a. REC'D BY REGISTRAR <u>DEC 6 '61</u>	25b. REGISTRAR'S SIGNATURE <u>Charles S. France</u>

(M)

Baltimore

Maryland

Rural White Hall

Rural - White Hall

White Hall Rd

White Hall Rd

Tillie J. Wright

Jan 21/1907 94

F W

Housewife

Can home York Co. Pa.

James Trent

Unknown

No

Mr. James Trent, White Hall, Md.

Box 12-61 West Liberty County White Hall, Md.

James Trent

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13718

CERTIFICATE OF DEATH

Items 8 & 9 Film 0304 12/20/61

13695

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2810 Emerald Ave.</u>		d. STREET ADDRESS <u>2810 Emerald Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Ethel A. Zerlant</u>		4. DATE OF DEATH <u>12 16 61</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-13-1888</u> 1890
9. AGE (In years last birthday) <u>71 1/2</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James P. Smith</u>		14. MOTHER'S MAIDEN NAME <u>Maggie Moore</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>Alice M. Garrett</u> Address <u>same</u>	
17. INFORMANT <u>Alice M. Garrett</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the colon with metastases to the liver</u> 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>to the liver</u> (c) <u>153.8</u> (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 6</u> 19 <u>50</u> to <u>Dec 16</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Dec 16</u> 19 <u>61</u> , and that death occurred at <u>11:58 P</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>E. J. Alessi</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>E. J. Alessi M.D.</u>		22d. ADDRESS <u>6217 Harford Rd</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>12-20-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		25a. REC'D BY REGISTRAR <u>DEC 20 '61</u>	
ADDRESS <u>5305 Harford Rd.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

12712



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